09-00745 Juan Johnson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2009 03001 State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day January 25, 2009 1354 hrs Medical Examiner Juan Johnson Jr. 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Baltimore Sinai Hospital N/A 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min Country) Md Director 10-22-1994 214-43-1631 1 X M 2 F 14 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Yes 2 No 28a-f show notified at once. Baltimore the Maryland Director 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 21215 4615 Reisterstown Road U.S.A with Funeral 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status "natural", or items Examiner must be 1 X Never Married 2 Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) death Married Specify: Black Yes If Yes, Give Year within 72 hours after Yes 2 No specify: Widowed 4 Divorced ģ "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Garrison Middle Pages 1 and 2 should be filed within 72 ment of Health and Mental Hygiene aut. If item 27 is marked other than "or other traumatic event, the Medical 1 Student School 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Juan Johnson, Sr. Cameo Mack 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21 21 5 19a. Informant's Name/Relationship (Type, Print) Baltimore, MD 2 permit, Pages I and 2 should Department of Health and M Important: If item 27 is m injury or other traumatic e Cameo Mack /Mother 4615 Reistertown Road Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State crematory or other place) Dundalk, Maryland Trinity Cemetery 2/4/09 Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature fruneral Service Licensia Chatman-Harris Funeral Hom 15240 Reisterstown Rd Baltimore Md 21215
representations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval 23a. Part I. Enter the disease **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. gunshot wound of head Immediate Cause (Fin disease kaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical UNPENDED AMENDED attending physician or use as the burial The law requires that the death certificate be Box 68760. 23d Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year Live birth Fetal death Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown o 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à Yes 2 No 3 Probably 4 ✔ Unknown Division of Vital Records, P. Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has death? performed? ✓ Yes 2 1 🗸 Yes certificate 26 Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medical Be examiner? Hospital: Other₄ Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 this 1 V Yes ٩ No 28d. Describe how injury occurred After 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? Certification: Jan 25, 2009 Subject shot 1333 hrs Natural Yes 2 V No I Director: ed in by the Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 4400 Blk. Pall Mall Road , Baltimore , MD determined (Specify) Local Street 4 V Homicide To the Funeral 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number OCME January 26, 2009 O.C.M.E. 30. Name and address of person who completed cause if eath (Item 23a Mi Kin 9 Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001 OCME 2006

Registrar

TEP O

certificate be executed Division or Vital Records, P.O. Box 68760, or Attending

Baltimore, Maryland 21215-0036

filled in by within 24 hours a To the Hospital completely

h Registrar

DHMH 17 Rev 1/2001

(Check only one)

29b. Signature and title of certifier

GIZAW WOLDEHIWOT, MD 2434 W. BELVEDERE AVE, BALTIMORE, MD 21215 31. Date filed (Month, Day, Year) 32. Registrar's Signature Beneva S.

Plum H. Wistofewor

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

20063327

29d. Date signed (Month, Day, Year)

JAN, 31,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Year **Physician** William Stewart 31 0 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8. Date of Birth (Month, Day, Year) Hospital Westminster arroll Carroll if Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 1 XM 2 ☐ F Director 79 212-24-7301 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If them 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar minst handled to the contract of the marked of the contract of the marked of the marked of the contract of the marked 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Director Maryland Carroll New Windsor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21776 1710 Wilt Road U.S.A. Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 TYes 2 □ No If Yes, Give Year or Dates: 1951-56 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify þ 3 ₩Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 nurse/ mail carrier hospital/ post office 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Howard K. Koons Viola I. Erb ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1922 Brown Rd. Finksburg, MD 21048 Patricia Dunphy/ daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Winters Cemetery 2/5/2009 nr. New Windsor, MD 21. Signature of Femeral Service Lig 22. Name and Address of Facility Hartzler Funeral Home affarine 310 Church St. New Windsor, MD 21776 23a. Part1. Enter the disease, or complications that used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** COP disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner FIBRILLATION TRIA Sequentially list conditions, from the cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Hospital or Attending PhysIclan: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, 🛠 and resulting in death) Last Due to (or as a consequence of) physician Physician/Medical the attending p 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1□Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has b irector, page 2 sl 24a. Was an autopsy performed 2 No 1∐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 9 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of Certification: 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifiei (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MAHBOOB AHRAFM D54330 2000 0

Registrar

State

7900 Wisconsin Ave., Suite 406

Bethesda,

MD 20814

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Ashraf

Mahboob 31. Date filed (Month, Day, Year)

FEB 0 4 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician AM Palmer M. Kane 2009 CBRUARY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Healthand Repapilitation Center HALFORD 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months Days Min. 1 XM 2 □ F Yrs. 21,1913 Maryland 95 August Director 218-09-2807 Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ∐ Yes 2∭ No Director Harford BelAir Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number US 1813 Conowingo Rd. 21014 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 2 should be filed within 72 hours after on and Mental Hygiene.

'is marked other than "natural", or iter 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Specify: Specify: White ģ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Union Construction Painter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sarah Paige ၉ Joseph Kane 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is m any Injury or other traum once. 838 Highland Rd. Street, Md.21154 Palmer E. Kane Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition cemetery, crematory Druid Ridge 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-5-2009 Balto. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 9705 Belair Rd. Nottingham, Md. 21236 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** lerit /Medical uto (or as a consequence of): Examiner arra Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a consequence of): Examiner at burial-trar Due to (or as a consequence of): Physician/Medical the as IF FEMALE for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 4 Unknown 3 Probably 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopo performed: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Hospital: 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 ☐ Pending investigation 1 ☐ Natural 1 ☐ Yes 2 ☐ No 2 Accident

the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, within 24 hours a

To the Funeral C

Saltimore, Maryland 21215-0036

Certification: To filled in by the

6 ☐ Could not be 3 ☐ Suicide

4 Homicide

29a. Certifier

(Check only one)

Medical

State Registrar 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day,

32. Registraris Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. NoZ U 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Jean Holbrook King 6:27 P 02-02-2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 336 Washington School Rd Rising Sun Cecil Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1 □ M 2 💢 F 68 MD 214-36-9033 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐Yes 2 X No Rising Sun MD Cecil 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21911 336 Washington School Rd 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XX No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Computer Edgewood Arsenal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Roy G. Holbrook Pearl M. Brooks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bel Air, MD 21015 2021 Ruffs Mill Rd Roy King (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 02-04-2009 Baltimore, MD Bayview Crematory 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licer 22. Name and Address of Facility Schimunek Funeral Home of BelAir Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CANCEL ING MONTHS Due to (or as a consequence of): MEDIASTINAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) METASTASIS BIN Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed: 1 Tyes 2 No 1∐ Yes 2 🔀 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Physician

Examiner

Funeral

Director

ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

within 72 hours after

permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygier. Important: If Item 27 is marked other than any Injury or other traumatic auchten than 1 man Injury or other traumatic auchten than 1 man Injury or other traumatic auchten 1 man Injury or other Injury or

Physician

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Hospital

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

funeral director,

Exami

Physician/Medical

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Completed

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1 Natural

2 Accident

4 ☐ Homicide

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

3 ☐ Suicide

5 Pending investigation

6 Could not be determined

sharme-

FEB 0 4 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certification:

Medical

Examiner

3altimore, Maryland 21215-0036

/Medical

Director

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Completed

Be

death certificate be executed Box 68760. P.O. Division or Vital Records, The or Attending

State

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D31856

1 ☐ Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

02/04/2009

EMMORTON LD # 120 SEL AIR MO

(Month, Day Year)

32 Registrar's Signature

Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Amend 19a, per FH g888 2/10/09 TT Please Type or Print in Black Indelible Ink Encure All Copies Are Legible.

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)	Examin		4a. Facility Name (If not institution	, give street ar	nd numbe	er)		4b. Cit	y, Town, o	r Location	of Death		4c.	County of De		
	· /		Johns Hopkins B	ayview					ultim		2411					
	Funeral Director		5. Social Security Number 217–34–8396	6. Sex 1 □ M 218		Age (In yrs. 70	. las <i>t birthday)</i> Yrs.	Month:	er 1 Year s Days	If Under Hours	Min.	8. Date of Birt (Month, Day 09/12/	y, Year)		ountry)	(State or Foreign
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ב כ	sician: The law certificate has b irector, page 2 s	m m										24a. Was autop	SV	prior to death?	complet	ndings available ion of cause of
			25. Was case referred to medical							00 51	- (B - 1)		med2 2 No	1 ☐ Ye		No
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5	ling Phys After this funeral di	n: To	27. Manner of Death		Date of Ir	niurv	28b. Time of		28c. Injur			28d. Describe h			еспу)	
5	ndin th. r: Aft	tio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investig		(Month, L	Day Year)	Injury	М		k? Yes 2 □	No					
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	2		30. Name and address of person v			f death (Ite	m 23a) (Type,	Print)				Baltin		- occi os	-12	
	6		Erica Rich		, mt	> 4	940 8	Eas	tern	Aver	lue	Baltin	mox	re, mo	21.	224
	Sta	te	31. Date filed (Month, Day, Year)	1	32. Regis	strar's Sign	ature	,								

DHMH 17 Rev 1/2001

1. Decedent's Name (First, Middle, Last)

2. Date of Death Month

death with the Maryland show r 28a-f sh notified "natural", or items 23a or dical Examiner must be filed within 72 hours after th and Mental Hygiene.
7 Is marked other than "natu traumatic event, the Medical

3altimore, Maryland 21215-0036

Physician /Medical **Examiner**

attending physician and for use as the burial-trar Division or Vital Records, P.O. Box 68760, director,

February 2009 11:29 A^M Stephanie R. Latterner 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 🕅 F Yrs. 91 December 26, 1917 Connecticut 044-09-0129 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2X No Maryland Montgomery North Potomac Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11552 Paramus Drive 20878 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: δ White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Federal Government Elementary/Secondary (0-12) College (1-4or 5+) and Hospital Accountant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked other any injury or other traumatic event Be John Richter Catherine Zabawa 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arthur G. Latterner / Son 11552 Paramus Drive, North Potomac, Maryland 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State February 8 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 2009 Rockville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda—Chevy Chase, Inc. M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. P.11. Force the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line.

Immediate Caus (Final Cardiac Pulmonary Arrest Due to (or as a consequence of): Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Massive Cerebral Vascular Accident Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has b irector, page 2 sl autopsy performe 1∐ Yes 2X No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☒ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 🕅 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00065505 M.D. February 2, 2009 elza 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NOI Medical Center Pr. Rockville, MD 9901 QIUFANG CHENG MO 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

Registrar

parke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 8:46 PM **Physician** January 28, 2009 Roy Moore, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Doctor's Community Hospital Lanham 9. Birthplace (State or Foreign Country) Virginia If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 X M 2 □ F Feb. 80 1928 227-24-7779 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10c. City, Town or Location 28a-f show ? Is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examinar must be rediffed at 1 □ Yes 2√TNo Director Prince George's Maryland Glenn Dale 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ermit. Pages 1 and 2 should be filed within 72 hours after death with t. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural". or item in injury or other traumatic event 20769 USA 10707 Brookland Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates: 1945-47 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 💢 No Specify: White Specify: ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Food Delivery 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Erthel Woodard Roy Moore ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10707 Brookland Road Glenn Dale, MD 20769 Gloria J. Moore/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland
Veterans Cemetery 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 2/9/2009 Cheltenham, MD 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licensee You ftail 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Kacertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3100 Good Luck RD LANHAM MO 31. Date filed (Month, Day, Year) State **FER 04** Parks Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Year Thomas 51 M McCurry 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltonine Acines Litospita 7. Age (In yrs. last birthday)
75 Yrs If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, **Funeral** 1**3**M 2□ F Months 040-28-0466 **Director** 01/28/1934 Usual Residence of Decedent 10a. State Show 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it. Medical Evaniment count by notified at once. MD Sykesville Carrol1 Funeral Director 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1002 Johnsville Road 21784 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 🎉 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 XNo Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Operations Manager Vendina 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John McCurry Edith Healy ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Georgianna McCurry / Wife 1002 Johnsville Road, Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Ardent Crematory 2/4/2009 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services 21. Signature of Funeral Service License Oorota Marshall llar Sio PO Box 1413, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Urosepsis /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐Yes 2 ☐ No Month Day Year 5 Other (specify) ed by the a detached f Division of Vital Records, P.O. 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably ♣ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 2 🗆 No 1 □Yes 1 ☐ Yes Attending Physician: completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 7 1 Inpatient မ 1 ☐ Yes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) after death. Director: After the 27. Manner of Death 1. Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Injury 5 Pending 1 ☐Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital or thin 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Es carro 900 Baltimore us 21229 Maria 40 atm 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar

DHMH 17 Rev 1/2001

Mc Carry

JANUARY 26, 2009 10:50 p.m. altimore. Marvland 21215-0036

Division of Vital Records, P.O. Box 68760	5	Bal	-
sion of Vital Records, P.O. Box 68760.		S.,	P
JAKEL ECCUBBLY Sion of Vital Records, P.O. Box 68760—			11
JAKEL MCCUBBIN Sion of Vital Records, P.		O. Box 68760,-	bottone od otnejšivon droch od
	MAKGAKEI MCCUDDIN	ital Records, P.	the diese Blanche from The law securiors that

		Please Type or State o	Print in Bla						
		1 - State Registrar			rtificate of i			Reg. No. 2 1 1	03010
		1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath Day Year	3. Time of Death
Physic /Medi		Margaret E. McCubbin					January	y 26, 2009	10:50 P ^M
Exami		4a. Facility Name (If not institution, give street and nu	mber)			r Location of Death		4c. County of Dea	
		Stella Maris Hospice 5. Social Security Number 6. Sex	7. Age (In yrs. las	t hirthday)	Timoni		8. Date of Birt	Baltimore 9. Bi	rthplace (State or Foreign
Funeral Director		212-34-8661 1□ M 2₺ F	72	Yrs.	Months Days	Hours Min.		y, Year) 26, 1936	Maryland
		Usual Residence of Decedent	10c. City, 7	T	4!				10d. Inside City Limits
arylar show	7	10a. State 10b. County			cation				1 □Yes 2X No
the M	Director	Maryland Harford 10e. Street and Number	Bel A	Air	10f. Zip Code			10g. Citizen of What C	Country?
with with	ā	1348 Vanderbilt Road			21014	, 1		US	
ms 2:	Funeral		edent Ever in U.S.	13.		Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No		
urs after death with the Marylan al", or items 23a or 28a-f show Examinat contilised at		1 ☐ Never Married 2 ☑ Married 1 ☐ Yes	2No		il res, specily oubli 1 ⊡Yes 2 DXNo	Specify:	o i noan, etc.)		White
ural",	d by	3 ☐ Widowed 4 ☐ Divorced Year or D	ates:	16a Door	dent's Usual Occur	action		16b. Kind of Busines	
be filed within 72 hours after death with the Maryland tal Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Execution must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)		(Give	kind of work done DO NOT use retire	during most of work	king	Too. Tana of Edolinos	or made a y
withi giene.	E O	Elementary/Secondary (0-12) College (1-4or 5+)	Ho	memaker			Own Ho	ome
al Hyg	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle,	Maiden Surname)	
Menta Menta arked atic e	2	Joseph Keenan				Marie			
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, I'm Monce.		19a. Informant's Name/Relationship (Type. Print) Patricia DeGuilmi (daugh			-	and Number or Ru Hill Rd.,		er, City or Town, State	, Zip Code) 21128
t and Health tem 27 tem 27 other to		20a. Method of Disposition			osition (Name of matory or other place		Date	20c. Location - City of	
Pages nent of int: If its		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ₺ Other (Specify)n t Omb m	State Re1		matory or other pla Mem Grdns		0/2009	Bel Air,	MD
nit. P artme ortan injur		21. Signature of Funeral Service Licensee	circ ber				- 1		ome of Bel Air
permit. Departr Importa any inji		11.0.0	2	1	610 W. Ma	acPhail R	d., Bel	Air, MD	21014
		23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on	caused the death.	Do not en	ter the mode of dyi	ng, such as cardiad	or respiratory a	rrest,	Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition a. REN	AL CELL C	CANCE	R				Shoot and Boat.
/Medical Examiner		resulting in death) Due to	(or as a conseque	nce of):					
	ē	Sequentially list conditions, if any, leading to immediate cauce. Enter Uncerlying Cause, (Disease or injury	(or as a conseque	nce of):					
executed and ial-transit	Examiner	that initiated events c,							
oe execian ar		resulting in death) Last Due to	(or as a conseque	nce of):					
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	d							
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requires requires been sign	ted								
e law has t	Completed						24a. Was auto perfo	psy prior to prior to death	
n: Th ficate or, pag		25. Was case referred to medical				26. Place of Day	1 ☐ Yes ath (Check only o		es 2 No
/sicia	To Be	examiner?	Inpatient 2 E	R/Outpatie	ent 3 DOA Ot	har:			pecify) HOSPICE
g Phy ge Phy ter thi	Ë	27. Manner of Death 28a. Date		28b. Time o		ury at		how injury occurred	
ending eath. or: Afte	Satio	2 Accident investigation				Yes 2 □ No			
or Att	Certification:	data-mined 200. Flat	e of Injury - At hom ling, etc. <i>(Specify)</i>	ne, farm, st	reet, factory, office		28f. Location (City or To	'Street and Number or wn, State)	Rural Route Number,
ppital ours a neral [29a. Certifier 1 ☐ Certifying Physician: To the	e best of my know	ledge, dea	th occurred at the	time, date and place	e, and due to the	e cause(s) and manner	as stated.
e Hos 124 h e Fur iletely	edical	(Check only 2 Medical Examiner: On the	basis of examination	on and/or i	nvestigation, in my	opinion, death occ	urred at the time	, date and place, and c	lue to the cause(s)
To th To th comp	Me	29b. Signature and title of certifier	ß		29c. Licen	se number		29d. Date signed (Mo	onth, Day, Year)
1		1 SANDSUNT			131	49196		1/27/2	009
5		30. Name and address of person who completed call				mTMONTT -	VD 011	,	
<u> </u>	tate	JACKIE JONES, CRNP 230 31. Date filed-(Month, Day, Year) 32.	O DULANEY Registrar's Signatu	re A	LEY KD.	TIMONIUM	, MD 210	בצו.	
Regis		FEB 0 4 2009 Ann	Registrar's Signatu	par	Co.				

09-00921 Jos

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

seph Miskiel	- 1	State of Maryland / Department of 1-For State Certificate of Registrar			g. No. 2009	9 0301
Physicia edical Examir	n/	1. Decedent's Name (First, Middle,Last) Joseph R. Miskiel		2. Date of Death Month January 31	Day Year	3. Time of Death 1759 hrs
		Facility Name (if not institution, give street and number) 821 Lynvue Road	4b. City, Town, or Location of Linthicum Heights	of Death .	4c. County of Death Anne Arundel	
Funeral Director		5. Social Security Number 215-30-1619 6. Sex 1 M 2 F 75 Y	If Under 1 Year If Under 1 Months Days Hours	Min	h (MM/DD/YYYY) 9. Birth Foreign 7 8,1934 Cou	
any.	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	ation			10d. Inside City Limits
*	ē		thicum			1 Yes 2 X No
vith the Maryland s 23a or 28a-f show a enotified at once.	Director	10e. Street and Number 821 Lynvue Rd.	10f. Zip Code 21090	10	g. Citizen of What Count US	ry?
ter death with the ", or items 23a	Funeral		Vas Decedent of Hispanic Orig f Yes, specify Cuban, Mexican Yes 2 X No specify:	, Puerto Rican, etc.)	14. Race - Americ White, etc.	
MOTE, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygene. Inter of Health and Mental Hygene. Inter of Free 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	ompleted by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	ent's Usual Occupation (Give most of working life. DO NOT	kind of work done use retired)	16b. Kind of Business/In	ndustry
Baltimore, MD 21215-0036 permit, Pages I and 2 should be filed within 7 Department of Health and Mental Hygene. Important: If Item 27 is marked other than injury or other tranmatic event, the Medica	ွျ	17. Father's Name (First, Middle, Last)		's Name (First, Middle, M	Maiden Surname)	Allines
2121 ould be fill d Mental H s marked lic event,	To B	Joseph Miskiel 19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ing Address (Street and Nun			Zip Code)
MD 2 sho salth and 2 sem 27 is raumati		David J. Miskiel Son	309 Caspian Cosition (Name of cemetery,	t. Edgewood	, Md. 21040	
Baltimore, permit, Pages I ar Department of Hes Important: If itel Important of or other tr		1 XBurial 2 Cremation 3 Removal from State crematory or 4 Donation 5 Other Specify: Ho1y Ros	other place)		Dundalk, Md	
Balti permit, Departi Import injury		telamo Kueki	Name and Address of Facility 9705 Belair	Rd. Notting	sham, Md. 21	
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not ente failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive athero	r the mode of dying, such as c	ardiac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
xaminer		or condition resulting in death) Due to (or as a consequence of):	Seletotic ear	41074504242		
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated				
e be executed ysician and burial - transit	1 Exar	events resulting in death) Last Due to (or as a consequence of):				
6 be executed sysician and burial - transit	edical	X UNPENDED AMENDED 23a,P11, 27,	per ME g888 2	/11/09 TT		
Division of Vital Records, P.O. Box 6876. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the b	žΙ	past 12 months?	Fetal death 3 Ectopi Other (Specify)	c pregnancy	23d. Date of delivery Month D	day Year
P.O. I es that the gned by the detached	by Ph	Part II. Other significant conditions contributing to death but not resulting in th	e underlying cause given in Pa		obacco use contribute to t	
Division of Vital Records, I al or Attending Physician: The law requires ris after death. al Director: After this certificate has been signed in by the funeral director, page 2 should be	Completed	<u>Esophageal cancer</u>		24a. Was a	an 24b. Were aut sy prior to co rmed? death?	topsy findings available ompletion of cause of
ian: Tl	Be Co	25. Was case referred to medical examiner?	26.Place of Death	(Check only one)		
n of Vit Iding Physic h. : After this e	To	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatie 27. Manner of Death 1 X Natural 5 Pending 1 Pending		k? 28d. Describe	Residence 6 Other	Scene
Divisional or Atters and or Atters at Director ed in by th	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specific) (Specific)	treet, factory, office building, e	tc. 28f. Location (\$ or Town, S	Street and Number or Rui state)	ral Route Number, City
Divisior To the Hospital or Attend within 24 hours after death To the Fineral Director: completely filled in by the	Medical Ce	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurrence one) ✓ Medical Examiner: On the basis of examination and/or investigation.	curred at the time, date and pl gation, in my opinion, death or	ace, and due to the caus	e(s) and manner as state and place, and due to the	ed. e cause(s)
To with	Mec	and manner stated. 29b. Signature and title of certifier	29c. License number O.C.M.E.	•	29d. Date signed (Mon	
		30. Name and address of person who completed cause of death (Item 23a)			. Obradily 1, 2009	
	ate	100 0	eet, Baltimore, MD 212	201		
Regist	rar	FEB 0 4 2009 Serve B. Spark				
DHMH 17 Rev 1/20	דטנ	ORIGIN	NAL	OCME		

DHMH 17 Rev 1/2001 OCME 2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Oliver McClary 2009 29 Jan. c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Sinai Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days 1 M 2 F S. Carolina 251-24-1359 1923 Feb. 85 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1√2 Yes 2 □ No Baltimore N/AMaryland 10g. Citizen of What Country? 10f. Zip Code 21215 2511 W. Coldspring Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Black 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Maryland State Elementary/Secondary (0-12) College (1-4or 5+) Security 9th grade Office Building 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lela McCrae Levine McClary 19a. Informant's Name/Relationship (Type. Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2511 W. Coldspring Lane Baltimore, Md 21215 Rachel McClary-Thompson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Arbutus Memorial Park 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from State Arbutus, Maryland 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215 21. Signature of Fund al Service Lice 23a. Part1. Ever the disease, complications that cause unshirt, or heart failure. If a only one cause on each line complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) oronar rear Due to (or as a consequence of): Sequentially list conditions, if any leading 1, immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ☑ ER/Outpatient 3 ☐ DOA 1 Inpatient 2 this funeral 27. Manner of Death 28b: Time of 28a. Date of Injury 28d. Describe how injury occurred Certification: 28c. Injury at Work? After (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death

To the Funeral Director:
completely filled in by the f 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated, 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D26534 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Price # 105 Devson MD Sister Pierre Marc So/Co/U 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ For	ertificate of Death		. No. 2 	03013
	Physicia	an l	1. Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year	3. Time of Seath
	/Medic		JAMES ALLISON MOREHEAD		JANUARY		5:00 P ^M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1	4c. County of Deat	h
			1803 SINGER ROAD 5. Social Security Number 6. Sex 7. Age (In yrs. last birthd	JOPPA If Under 1 Year If Under 24 Hrs.	8. Date of Birth	HARFORD 9. Birt	hplace (State or Foreign
	Funeral Director		296-24-8809 1 M 2 □ F 78 Usual Residence of Decedent	Months Days Hours Min.	8. Date of Birth (Month, Day,) Jan. 2,	Year) Co 1931	Ohio
	/land		10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	Man a-fsh	tor	Maryland Harford Joppa				1 ∐ Yes 2 MXNo
	or 28)ire	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Co	untry?
	23a d	Funeral Director	1803 Singer Road	21085		USA	
	r dea	nne		 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerte 	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White	
36	or if	by F	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 X No Specify:		Specify:	4.0
Maryland 21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. dother than "natural", or items 23a or 28a-f show event, the medical Evain increment be notified at	ed b	15 Decedent's Education 16a, De	ecedent's Usual Occupation	16	Sb. Kind of Business/	lite Industry
15	_ 3	Completed	(Specify only highest grade completed) (G Elementary/Secondary (0-12) College (1-4or 5+)	ive kind of work done during most of wor e. DO NOT use retired)	king		
212	d within giene.	E O		lectrician		U.S. Gov	ernment
b	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, In Ma	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Nam	ne (First, Middle, Ma	aiden Surname)	
<u>la</u>	should be and Mental s marked o	2	Chester Allison Arthur Morehead		. Wade Ect		
ar	2 sho and Is ma		(),	ailing Address (Street and Number or Ru			
	ges 1 and 2 should it of Health and Mer if item 27 is marke or other traumatic		T GOOD T & TROTCHCOO / WILL	03 Singer Road, Jor		Land 21085 Dc. Location - City or	
Baltimore,	ges 1 If ite or ot		1 LXBurial 2 Li Cremation 3 Li Removal from State	sposition (Name of crematory or other place)		Š	
Ħ.	t. Pa rtmer rtant:			w Memorial Gdn. 1/3	30/2009	Fallston,	Maryland
Bal	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Ferrice Ligensee	22. Name and Address of Facility Mo 1317 Cokesbury Roa			
			23a. Fart 1. Enter the disease, or complications that caused the death. Do not				Approximate
	Discolation					· ·	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) a. Due to (or as a c resequence of):	vartery Dise			
T	Examiner		CORMAR	vartery Dise	950		
	B #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			(3)	
	ecute ind transi	Examiner	Cause (Disease or Injury that initiated events c				
68760,	ificate be executed g physician and as the burial-transit		resulting in death) Last Due to (or as a consequence of):				
87	physi the k	edical	d				
			IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of de	livery
Вох	The law requires that the death certif ate has been signed by the attending age 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month	Day Year
Ö	t the o	hys	9 Unknown				
о, С	s that gned	by P	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.			the cause of death?
ğ	w requires to s been signer should be co				1 □ Yes	2 □ No 3 □ Pi	robably 4 Onknown
of Vital Records	e law ru has be je 2 sho	Completed			24a. Was an autopsy	prior to	utopsy findings available completion of cause of
E .		į			perform 1 □ Yes 2	ed? death? ☑No 1 ☐ Yes	s 2□No
/ita	siclan: Th certificate rector, pag	Be	25. Was case referred to medical examiner? Hospital: Hospital:	Othor	ath (Check only one		
of	S 0 =	은	1 Yes 2 No 1 Inpatient 2 EH/Outp		lome 5 Resider 28d. Describe how	nce 6 Other (Spe	ecify)
	ding h. After fune	ë	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) Inju		Zod. Dodo. Bo Nov	v mary cocarroa	
Division	I or Attending after death. Director: After in by the funer	fical	3 Suicide 6 Could not be 28e Place of Injury - At home farm		28f. Location (Stre	eet and Number or R	ural Route Number,
Σ	pital or Attenions after deatleral Director:	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or Town,	State)	
	To the Hospital within 24 hours a To the Funeral completely filled	Medical C	29a. Certifier (Check only one) 1 Certifying Physiclan: To the best of my knowledge, one and manner stated.	death occurred at the time, date and plac or investigation, in my opinion, death occ	e, and due to the ca urred at the time, da	use(s) and manner a te and place, and due	s stated. e to the cause(s)
	Fo the vithin Fo the compliants	Me	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Mont	th, Day, Year)
	~~		5 La fondel	D.75x125		1/7	1/07
	۱ / ز ر		30. Name and address of person who completed cause of death (item 23a) (Ty	pe, Print)		119	1-(
1	111			side Pkwy, Belcamp,	MD 21017	7	
	Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature	bracked			

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	Ctate of Wie	-	•	ificate of l			Reg. No.	2009	03014
	Physicia	an	1. Decedent's Name (First, Middle, Las						2. Date of Dea	Day	Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give		urel	Mor T	ton 4b. City, Town, or	Location of Dea	Januar	-	2009 County of Death	3 27 A ^M
	Examin	er	Frederick Memori		a 1		Freder				rederic	
I	Funeral Director		5. Social Security Number 6. Security 1 6. Security 1 6. Security 1 6. Security 1 7 7 8 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9		(In yrs. last birt	hday)_ Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		h	Q Rirth	nplace (State or Foreign intry) MD
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Loca	ation					10d. Inside City Limits
	Maryl.	tor	MD N/A		Balti	mor	е					X☐Yes 2☐No
	r 28a	irec	10e. Street and Number				10f. Zip Code			10g. Citiz	en of What Cou	untry?
	th with	al D	1109 Webb Cou	rt			2120				S A	
900	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Exerting the Losting and once.	d by Funeral Director	11. Marital Status 1	12. Was Decedent E Armed Forces? 1 Yes Sive If Yes, Give Year or Dates:	lo	11	□Yes 2【XNo	Specify:	Specify Yes or No rto Rican, etc.)			lack
21215-0036	within 72 h ene. than "natu ne Medica	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 12th grade	College (1-4or 5		(Give k	ent's Usual Occup ind of work done on O NOT use retired	during most of we	orking	16b. Kin	d of Business/I	ndustry
	illed I Hygl other ent, I	BeC	17. Father's Name (First, Middle, Last)		, ,			18. Mother's Na	me (First, Middle,	Maiden S	Surname)	
ılan	vid be Venta rked rtic ev	To B	Carlton Morton					Lori E	urgess		_	
Maryland	2 shou and N is ma auma		19a. Informant's Name/Relationship (7	Type. Print)	19b.	Mailing	Address (Street	and Number or F	Rural Route Numb	er, City or	Town, State, Z	ip Code)
	os 1 and 2: of Health a item 27 is		Lori A. Burges	s-Mother			9 Webb ition (Name of	Court	Balto, M		1202 cation - City or T	Town State
Baltimore,	. Pages 1 tment of H tant: If ite		20a. Method of Disposition ★★Burial 2 □ Cremation 3 □ 4□Donation 5 □ Other (Specify	<i>'</i>)	cemeter	y, cřema Mem	atory or other place orial I	2k 2-2	-2009	Rand	dallst	own, MD
Ball	permit Depar Impor any in		21. Signature of Funeral Service Licen	NE Ferde	<i></i>	1	101 E.	North	arch Ea Avenue	Bali	736	
68760,	Physician and by Medical Examination and by Sician and as the burial-transit	cal Examiner	23a. Part1. Enter the disease, or company shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as Due to (or as Due to (or as	ie.	on:			Signod		g	Approximate Interval Between Onset and Death
P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 ▼ No 9 □ Unknown	23c If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal death		Ectopic pregnand Other (specify)	y		2	3d. Date of deli	very Day Year
	uires that i n signed by	d by Ph	Part II. Other significant conditions of	ontributing to death b	ut not resulting ir	the un	derlying cause giv	ren in Part I.			29	the cause of death?
Division of Vital Records,	The law rec cate has bee page 2 shou	Completed		av					24a. Was auto perfo 1 X Yes		prior to o death?	topsy findings available completion of cause of
Vita	ician: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:			Oth	or:	eath (Check only o			
on of	ding Phys h. After this funeral dir	Certification: To	1 Yes 2 No 27. Manner of Death The Natural 5 Pending 2 Accident investigation	28a. Date of Inju		tpatient Time of njury	28c. Inju	4 🗆 Nursing	Home 5 Resi			cify)
Divisi	al or Attens after deal	ertifica	3 Suicide 6 Could not be determined	28e. Place of Inju	ury - At home, fa c. (Specify)	rm, stre	et, factory, office		28f. Location (City or To			ral Route Number,
	e Hospita 124 hours e Funera letely fille	Medical C	29a. Certifier Certifying Ph (Check only one) 2 Medical Exam	nysician: To the best niner: On the basis of and manner sta	f examination ar	e, death	occurred at the trestigation, in my	ime, date and pla opinion, death oc	ce, and due to the curred at the time,	cause(s) date and	and manner as place, and due	s stated. to the cause(s)
	To th withir To th сотр	Me	29b. Signature and title of certifier				29c. Licens	se number		29d. Date	e signed (Monti	n, Day, Year)
			(VITAR-TO	MA			100	51610		1/	27/09	
	2 1		30. Name and address of person who	e.				MD	21707	1		
	Sta	ate.	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	136	CTI I	/ / 1-	41100			
	Regist			009 Denes	un A.	1	aver					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene 25 per verbal 888.02/03/08dhb Certificate of Death Reg. No. 2009 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mitchell Day Year Month **Physician** 1142 ICKIE 28 2009 January /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner n/a Baltimore City The Johns Hopkins Hospital 8. Date of Birth (Month, Day, Year)
Dec. 30, 1966 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 42 216 94 3008 MD **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show Yes 2 □ No the Medical Examiner must be notified at Director 28a-f n/a Baltimore MD 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number ö 2311 McElderry St. 21205 USA items 23a Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 Yes 2 No Specify <u>ک</u> Specify: white 3 Widowed 4 Divorced Year or Dates: "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene is marked other than 12th Ravens Cab Dispatcher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Stanley Grebos Irene Bobitt ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Rose St. Baltimore, Md. Stanley Grebos father 919 N. 21205 Department of Healt Important: If item 2 any injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Green Mount Crematory 30,2009 2 Fremation 3 F 5 Other (Specify) 1 D Burial Balto, Md. ²² Name and Address of Facility Calvin B. Scruggs Funeral Home of Funeral Service Licenses 21. Signature 412 E. Preston St. Balto, Md. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Due to for as a consequence of): 5 months **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760. Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy the funeral director, page 2 should be detached for in the past 12 months? Month Day Year 4 Pregnant at time of death
9 Unknown 5 Other (specify) 1 Yes 2 No 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2X No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence Hospital: 1 Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) မ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident Director: After 5 Pending investigation Injury 1 Tyes 2 No 6 Could not be determined 3 🗌 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide hours after Hospital within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

ပ

thlan, RThomas Jams Hopkins Hospita 31. Date filed (Month, Day, Year) 32. Registrar's Signature

600 North Wolfe St, Baltimore, MD, 21287

January 28, 2009

FEB 0 4 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kes - 000

maxilizes & Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	•	For State Registrar	State of Mary	rand / Depa <i>Cei</i>	rtificate of l	ieaith and r Death		eg. No.	03016
Physicia		1. Decedent's Name (First, Middle, Last, Elaine C.					2. Date of Death Month Jan.	30,2009	3. Time of Death 4:40P M
/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death	1	4c. County of Deat	
6		Gilchrist / Cen			Towso			Baltime	
Funeral Director		221 01 2220	7. Age (III	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Apr. 4	Year) 9. Birt Co	hplace (State or Foreign untry) D
e Maryland 3a-f show	ctor	Usual Residence of Decedent	10	c. City, Town or Lo Balt	cation imore				10d. Inside City Limits 1⊠Yes 2□No
3a or 28	al Dire	10e. Street and Number 6152 Marlora Ro	ad		10f. Zip Code 2123	9	10	ng, Citizen of What Co USA	untry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evand har must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		Was Decedent of H If Yes, specify Cuba 1 □Yes 2□No	ispanic Origin? (S n, Mexican, Puerti Specify:	pecify Yes or No- Decify Yes or No- Decify Yes or No-	14. Race - Ame Black, White	e, etc.
vithin 72 hou ine. han "natura	Completed	15. Decedent's Edu (Specify only highest grad	cation	(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of won l)	king	16b. Kind of Business/l	Industry
ld be filed w lental Hygie ked other t iic event, In	To Be Co	10 th 17. Father's Name (First, Middle, Last) Arnold Jenki	ns	S	elf emp	18. Mother's Nam	ne (First, Middle, N tevenso	faiden Surname)	1001401
and 2 shou salth and M n 27 is mar er traumat	-	19a. Informant's Name/Relationship (7) William Matthew	s (husban	d) 130	6 Kitmo	re Rd.		City or Town, State, 2	
Pages 1: ment of He tant: If iten lury or oth		20a. Method of Disposition 1 ☐ Burial 2 反 Cremation 3 ☐ F 4 ☐ Ponation 5 ☐ Other (Specify)	Removal from State	Green M	sition (Name of matory or other place) Ount Cr	ematery	3,2009	Baltimo	re, Md.
permit Depart Import any Inj once.		21 Signature of Funeral Service Licens	Lowey	/	Calvin 1412 E.	B. Scru Presto	ggs Fun n St. B	eral Home	Md.21213
Physician /Medical		23a. Part 1. Enter the disease, or compl shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ications that dusted the ne cause on each line. a. END STA: Due to (or as a second				or respiratory arre	est,	Approximate Interval Between Onset and Death
Examiner	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	nsequence of):					years
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	☐ Ectopic pregnanc☐ Other (specify) _	у		23d. Date of del Month	ivery Day Year
quires that to signed by all be detact	þ	Part II. Other significant conditions co	ntributing to death but no	ot resulting in the u	nderlying cause giv	en in Part I.		s 2 No 3 Pr	the cause of death? obably 4 🔏 Unknown
ding Physician: The law re. h. After this certificate has bee funeral director, page 2 sho	Completed	CARDIOMY OPATHO VENTRICULAR TO DEEP VENOUS	THROME	30515			24a. Was ar autops perform 1 □ Yes 2	y prior to oned? death?	topsy findings available completion of cause of
ician; certifi ector,	Be	25. Was case referred to medical examiner?	doenital:		Oth		th (Check only one		41
Phys r this ral dir	<u>۲</u>	1 ☐ Yes 2 No 27. Manner of Death	1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatie		4 □ Nursing H	ome 5 Reside	nce 6 Other (Spe	cify) HOSPICE
tending death. tor: After the fune	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day, Ye	ear) Injury	M 1 🗆	Yes 2 □ No			
ital or Al	Certifi	4 Homicide determined	28e. Place of Injury - building, etc. (\$	Specify)	eet, factory, office		28f. Location (Sti City or Town	reet and Number or Ru , State)	irai Houte Number,
ne Hosp n 24 hou ne Funer	Medical		sician: To the best of m iner: On the basis of ex and manner stated	amination and/or ir					
To ti withi To ti	ž	29b. Signature and title of certifier	2		29c. Licens	e number	25	9d. Date signed (Monti	h, Day, Year)

State Registrar DANIEUE DOBERMAN,
31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

rson who completed cause of death (Item 23a) (Type, Print)

mo

D64395

6565 N CHARLES ST, SUITE 209

JANUARY 31, 2009

BALTIMONE, MO 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	•	For State Of IVI	aryland / Dep <i>Ce</i>	ertificate of l			eg. No 2 0 0 5	03017
Physicia		1. Decedent's Name (First, Middle, Last)				2. Date of Deat Month	h ry ^{Day} 28, 200	3. Time of Death
/Medic	al	Theresa Minnick	1	4h City Town or	Location of Death	Januar	4c. County of De	
Examine	er	4a. Facility Name (If not institution, give street and number, Montgomery General Hospi	_	4b. Oity, 10mi, of	Derwood		Montgor	
Funeral Director		577-32-9858 1□M 28F	ge (<i>In yrs. last birthda</i> y 80 Yrs.	// If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 02/20	/1928 M	irthplace (State or Foreign Country) D
land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation	<u> </u>			10d. Inside City Limits
Mary a-f sh	햣	MD Montgomery	Silver	Spring				1 ☐ Yes 2 ☑ No
or 283	Director	10e. Street and Number		10f. Zip Code		1	0g. Citizen of What 0	
ath wi	la l	3209 Whispering Pine Dr.	T	20908		" W	United S	
S	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced 12. Was Decedent Armed Forces' 1 □ Yes 2 ☒ If Yes, Give Year or Dates:		. Was Decedent of H If Yes, specify Cuba 1 □Yes 2 ☑ No	Ispanic Origin? (Spe an, Mexican, Puerto	Rican, etc.)	Black, Wh	nerican Indian, ite, etc. Thite
72 hg	letec	15. Decedent's Education (Specify only highest grade completed)	16a. Dec	edent's Usual Occup re kind of work done o DO NOT use retired	ation during most of working	ng	16b. Kind of Busines Own Home	s/Industry
d ZTZT	Completed	Elementary/Secondary (0-12) College (1-4or	5+)	emaker	,,			
000	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, I	Maiden Surname)	
/land	일	William Thompson			Anna H	arding		
Ore, Maryland les 1 and 2 should be file t of Health and Mental Hy if item 27 is marked othe or other traumatic event.		19a. Informant's Name/Relationship (Type. Print) Nina Seek/Cousin					r, City or Town, State MD 20784-	, Zip Code)
Pag ment ury o		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Chesap	position (Name of ematory or other place eake Crema	atory	Feb 3 2009	20c. Location - City o	e, Maryland
Dalt permit. Depart Import any Inj once.		21. Signature of Funeral Service Agensee	M00382	22. Name and Addre Rapp Fune 933 Gist	ral & Crem	ation Se er_Sprin	rvices g, Maryland	1 20910-
Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death) Due or as	d the death. Do not e ine.	L .	ng, such as cardiac o	or respiratory arr	est,	Approximate Interval Between Onset and Death
icate be executed physician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	S a consequence of):					
8 / 6(ate be hysicia the bur	edical	d						
Hecords, P.O. Box 61 The law requires that the death certific ate has been signed by the attending p age 2 should be detached for use as in	Physician/Me		2 Fetal death 3	B ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у		23d. Date of o	lelivery Day Year
dS, P	ģ	Part II. Other significant conditions contributing to death	but not resulting in the	underlying cause giv	en in Part I.		1.1	to the cause of death? Probably 4 🗆 Unknown
VItal Hecords, iclan: The law requires t certificate has been signe rector, page 2 should be o	Completed	N - 5				24a. Was a autops	med death	
	Be	25. Was case referred to medical			26. Place of Death			es 2 No
ysici	10 B	examiner? 1 Yes 2 No Hospital: 1 Input	ient 2 🗆 ER/Outpat	ient 3 DOA Oth	er: 4 \(\text{Nursing Ho} \)	me 5 Reside	ence 6 Other (S	pecify)
On of V	ion:	27. Mann- of Death 28a. Date of In (Month, D	jury 28b. Time ay, Year) Injury	/ Wor	yat k? Yes 2 ⊡No	28d. Describe ho	ow injury occurred	
or Atten or Atten after deat Director: in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Ir building, 6	njury - At home, farm, s etc. <i>(Specify)</i>			28f. Location (S City or Town	treet and Number or n, State)	Rural Route Number,
To the Hospital within 24 hours a To the Funeral I completely filled	edical (29a. Certifier (Check only one) 1D CertifyIng Physician: To the besi and manner s	of examination and/or	ath occurred at the ti investigation, in my o	me, date and place, opinion, death occurr	and due to the o	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
To the I within 2 To the I complete	Me	29b. Signature, and title of certifier HOSpil	talist	29c. Licens 1000	se number 05-9414	,	29d. Date signed (Mo	nth, Day, Year)
121		30 Name and and less of person who completed cause of	death (Item 23a) (Type	e, Print) RM. RAKHM	NIN MD.	18101 PI	PINCE PHIL	1P DR 20832
Sta Registr		31. Date filed (Mohth; Day, Year) 7. Regis	ViADIMII trar's Signature	arkal				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 2000 Meluh Marcie Ann Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death N/A Date of Birth (Month, Day, Birthplace (State or Foreign Country) (In vrs. last birthday) Security Numbe Min. Year Months Days Hours 1 □ M 2 🗙 F 262-15-6753 55 JUN 27 1953 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2X No Carrol1 Wesminster 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21158 USA 308 Wampler Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 1 Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry Therapeut for Recreation Elementary/Secondary (0-12) College (1-4or 5+) Health Care Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ε. Kinsey Anne 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 103 Sonata Way, Centreville, MD 21617 Gaye Baker - sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory, Inc. 02/03/2009 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) ²²Cremation Society of Maryland, Inc. Steven H. Williams 21228 299 Frederick Road, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSI disease or condition resulting in death) Due to (or as a consequence of): NEGA TIVE BACTERENIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last LHONIC VALUE ENDOCARD Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes a □No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manual of Death

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

burial-transit and attending physician for use as the buria After this certificate has been signed by the funeral director, page 2 should be detached

Physician

/Medical

Examiner

Funeral Director

þ

Be Completed

ဥ

Physician/Medical Examiner

Be Completed by

Medical Certification: To

MD

UNK

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examinating the rediffied at once.

Physician

/Medical

Examiner

 \mathcal{HRLIE} \mathcal{NEL} Baltimore, Maryland 2121

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

State Registrar

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only

29c. License number

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

1 critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29b. Signature and title of certifier

5 Pending investigation

6 ☐Could not be determined

RES 000

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

02,01,2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HANTA KASSEM 560 (10C/1 RAVEN MD TIMOR

31. Date filed (Month, Day, Year) FEB 0 4 2009

28a. Date of Injury (Month, Day, Year)

and manner stated.

			Plea					ndelible lnk		-		egible.	
	-	For State		State	of Ma	arylan		partment of F Partificate of			_	000	02010
		1. Decedent's Name	e (First, Middle	e, Last)				or inoate or	Douth	2. Date of Dea		UUJ	3. Time of Death
Physicia /Medic		JEI	ROME				MAZE	R		JÄNÜAR	Y 31	2009	3:10 P M
Examin		4a. Facility Name (/		n, give street and			T CTF		r Location of Death		1	unty of Death	
Funeral Director		5. Social Security N	lumber	6. Sex 1 💢 M 2 🗆 F	7. Ag	e (In yrs. I			If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 02/26/	h v. Year)		pplace (State or Foreign intry) MD
pui w		Usual Residence of 10a. State					, Town or	Location					10d. Inside City Limits
the Marylar 28a-f show	Į.	MD	BALT]	MODE		100. 011		IMORE					1 □Yes 2 No
h the	irec	10e. Street and Nur		MONE			DAL	10f. Zip Code			10g. Citizer	of What Cou	intry?
ath wit	ral	7202 RO	CKLAND	HILLS DE				212				USA	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status1 ☐ Never Marri3 ☐ Widowed		ried 1 🕅 Ye	ecedent Forces? s 2 Give r Dates:		S. 1;	3. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🔏 No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Pican, etc.)		Race - Amer Black, White, pecify: WH	
72 hot natura	Be Completed	(Spec	15. Deceden	t's Education st grade complete	ed)			cedent's Usual Occup ve kind of work done		ina	16b. Kind	of Business/li	ndustry
within ene. than "	duc	Elementary/Seco	ndary (0-12)	T	e (1-4or 5	5+)		o. DO NOT use retire NER / AGEN	*		RFA	L ESTA	TF
il Hygi other ent,	Se C	17. Father's Name		Last)			0111	(EIX) / (GE)	18. Mother's Nam	e (First, Middle,			
Menta Menta arked atic ev	10 E	EMMA	NUEL			MAZE	R		SAR	RAH		BROT	MAN
12 sho		19a. Informant's N					1	ailing Address (Street					
Pages 1 and nent of Health int: If Item 27 iry or other t		CONSTANC 20a. Method of Dis		R / WIFE		20b. P	loop of Die	nasitian (Name of		Date #40		tion - City or T	E, MD 21209 Town, State
Pages nent o ant: If I		1 X Burial 2 4 Donation		3 ☐ Removal fro Specify)	m State	MIR	ROOK(POESHOU (Name of POESH other plan RAEL CONG.	02/03	3/2009	BAL	TIMORE	, MD
permit. Departr Importa any Inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208											
<u> </u>		23a Part 1 Enter 1	the disease of	complications the	the street	d the death	Do not	8900 REI				SVILLE	, MD 21208 Approximate
Physician		shock, or hea Immediate Cause	art failure. List (Final	only one cause o	n each li	ine.			ng, saon as cardiae	or respiratory a	11631,		Interval Between Onset and Death
/Medical		disease or condition resulting in death)	on	a. Due	to (or as	a consequ							11/07HV2
Examiner	<u>.</u>	Sequentially list co	onditions,	b	to (or as	a consequ	ience of).						
ansit ansit	Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events	erlying r injury	S c	10 (01 43	a consequ	action oi).						
be executed cian and ourial-transit		resulting in death)	Last		to (or as	a consequ	uence of):						
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the buri	Physician/Medical	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 I 9 ☐ Unknown	? months? □ No	4 □ P	ve birth	of pregna 2 □ Feta at time of d	l death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	су		230	d. Date of deli Month	very Day Year
s that t med by e detac	by Ph	Part II. Other signi	ificant conditi	ons contributing t	o death l	out not resu	ulting in the	e underlying cause gi	ven in Part I.	23e. Did t	obacco use	contribute to	the cause of death?
equire een sig rould b		<u>Diab</u>	etes							1 🗆 `	Yes 2 🗆 I	No 3□ Pro	obably 4 Unknown
: The law r cate has b	Completed	COM	ary ar	tey ai	20	(SÉ				24a. Was autor perfo 1 □Yes		24b. Were au prior to d death? 1 ☐ Yes	topsy findings available completion of cause of 2 ☐No
slcian certifi	Be	25. Was case reference examiner?	rred to medica	Hospital:			FD/0-4	V A D DOA Otl	26. Place of Dea		1	hau	··· Non Oir a
g Physical this seral di	n: To	1 ☐ Yes 2 ☐ 27. Manner of Dea		28a. D	ate of Inj	ury	28b. Time Injur	of 28c. Inju	4 LI Nursing n	ome 5 Resi		Other (Spec	city) +OSQUICO
tendin eath. or: Af the fur	catio	Natural 2 Accident	5 ☐ Pendii investi 6 ☐ Could	gation	70mm, D	ay, rear)	- Injur		Yes 2 No				
al or At s after d Il Direct ed in by	Certification: To	3 ☐ Suicide 4 ☐ Homicide	deterr	oined 286. Pl	ace of In uilding, e	jury - At ho tc. <i>(Specif</i>	ome, farm, (y)	street, factory, office		28f. Location (City or To		Number or Ru	ral Route Number,
ie Hospit 24 houri ie Funera iletely fille	Medical (29a. Certifier (Check only one)		Examiner: On the		of examina		eath occurred at the trinvestigation, in my					
Vithii To th	Me	29b. Signature and	d title of certifie	or				29c. Licen			29d. Date s	signed (Month	, Day, Year)
ì		Cobi	ecca.	Settle	0	CRN	P		5356		rebuc	my 1,	2009
6		30. Name and add	ress of person	who completed of	ause of	death (Iten	n 23a) (Typ		on MA	21204		7	
Sta		31. Date filed (Mon	nth, Day, Year	3	. Regist	trar's Signa	iture	arked	O CINO	- · · · · · ·			
Registr	ar	-	EB 04	2009 1/2	ne Park	v p	· fige	aver					

		-	For State Registrar	State of Mary	•	artment of He ertificate of De			iene :g. No.2 () () 9	03020
	Physicia	10	Decedent's Name (First, Middle, La	st)			T	2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	Onda IV	estor		4b. City, Town, or Lo		JAN4 A B	4c. County of Deat	
	Examin	er	4a. Facility Name (If not institution, gi			Bel A			HARFOR	
	Funeral	1	Social Security Number 6.	Sex 7. Age (In	yrs. last birthday		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 10-31-19		hplace (State or Foreign untry)
	Director		234-64-9713 Usual Residence of Decedent	1□M 27√2F 8	9 Yrs.			10-31-19	919	WV
	yland at		10a. State 10b. County	100	c. City, Town or L	ocation				10d. Inside City Limits
	e Mar Ba-f st	Director	MD Harf	ord	Jo	ppa		-		1 ☐ Yes 2¶ No
	with th	Dire	10e. Street and Number 725 Falconer Rd			10f. Zip Code 21014		11	0g. Citizen of What Co USA	untry?
	ns 23	Funeral	11. Marital Status	12. Was Decedent Ever	in U.S. 13.	Was Decedent of Hisp If Yes, specify Cuban,		city Yes or No-	14. Race - Ame	
920	should be filed within 72 hours after death with the Maryland of Mental Hygiene. and Mental Hygiene. marked other than "natural", or items 23a or 28a-f show marked other than "natural". matic event, the Medical Examirer must be notified at	by	1 □ Never Married 2 □ Married 3 🖾 Widowed 4 □ Divorced	Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:			Mexican, Puerto I	Hican, etc.)	Black, White	e, etc. Mite
<u>2</u> -0	72 hc	Completed	15. Decedent's E (Specify only highest gi	ducation ade com <i>pleted)</i>	16a. Dec	edent's Usual Occupation with edition of work done dur DO NOT use retired)	ion ring most of workir	ng	16b. Kind of Business/ Carls Mote	
121	filed within Hygiene. other than ent, the Me	ошо	Elementary/Secondary (0-12)	College (1-4or 5+)		r & Operat			and Restau	
פַ	al Hygi other vent, II	Be C	17. Father's Name (First, Middle, Las	")		1	8. Mother's Name	(First, Middle, M	faiden Surname)	
ylaı	should be and Mental s marked o umatic ev	10	George S. Lough				Ocie Nes			
Z Z	2 S S S S S S S S S S S S S S S S S S S		19a. Informant's Name/Relationship Nellie G. Holle		1	ing Address (Street and Falconer R		Route Number, • MD 210	-	Zip Code)
ē,			20a. Method of Disposition			osition (Name of ematory or other place)			20c. Location - City or	Town, State
E E	Pages nent of int: If it		1 Burial 2 Cremation 3 € 4 Donation 5 Other (Spec	J Removal from State		Cemetery	02-02	-2009	St. George	e. WV
Baltimore, Maryland 21215-0036	permit. Pages 1 am Department of Heal Important: If Item 2 any Injury or other once.		21. Signature of Funeral Service Lice	nsee	2	nc. 610 W.	of Facility Sch	imunek I	Funeral Hor	ne of BelAir
			23a. Part T. Enter the disease, or cor shock, or heart failure. List only	plications that caused the one cause on each line.	death. Do not e	nter the mode of dying,	such as cardiac o	r respiratory arre	est,	Approximate Interval Between Onset and Death
3	Physician		Immediate Cause (Final disease or condition resulting in death)	a. ACUTE	MYECA	RDIAL IN	VFARCTIO	N		Oliset and Death
	/Medical Examiner		resulting in death)	Due to (or as a co	nsequence of):					
		Je.	Sequentially list conditions,	b. Due to or as a co	ns quence of):					
	lansit of died	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С						
68760,	ificate be executed g physician and as the burial-transit		resulting in death) Last	Due to (or as a co	nsequence of):					
89		Medical	IE ECNANIE.							
O. Box	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of de Month	livery Day Year
٠ <u>.</u>	iires that I signed by d be deta	y Ph	Part II. Other significant conditions	contributing to death but no	ot resulting in the	underlying cause given	in Part I.	23e. Did tot	pacco use contribute to	the cause of death?
ğ	w requires been sig should by	ed b	HYPERTENSION,	DIABETES	MECLIT	US, ANEA	MIA,	1 □ Ye	s 2∭2No 3∏P	robably 4 Unknown
Division of Vital Records,	Physician: The law re this certificate has be al director, page 2 sho	Completed by	CHRONIC RENAC	. INSUFFICI	ENCY			24a. Was a autops perforn 1 □Yes	ned? death?	utopsy findings available completion of cause of
/ita	iclan: sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:		Othor	26. Place of Death			
of	Phys r this ral dir	7: To	1 ☐ Yes 2 ② No 27. Manner of Death	28a. Date of Injury	2 ☐ ER/Outpati 28b. Time	of 28c. Injury a	4 Nursing Hor		ence 6 Other (Spe ow injury occurred	ecify)
on	nding Ph ath. r: After th e funeral	atior	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Ye	ear) Injury		es 2□No			
Divis	al or Atte s after des I Directo d in by th	Certification: To	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		At home, farm, s Specify)	treet, factory, office	1	28f. Location (St City or Town	reet and Number or R. n, State)	ural Route Number,
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	Medical C	29a. Certifier Check only one) Certifying F	Chysician: To the best of maminer: On the basis of examiner stated	amination and/or	ath occurred at the time investigation, in my opi	e, date and place, inion, death occurr	and due to the c ed at the time, d	ause(s) and manner a ate and place, and due	s stated. e to the cause(s)
	To the comp	ME	29b. Signature and title of certifier			29c. License	number	2	9d. Date signed (Moni	
				your M.			344_		01/29/20	009
	3		30. Name and ress of person of SURESH DHANZ	completed cause of death	(Item 23a) (Type	e, Print)	HANDE D	FCIZHE	E 171 71	78
	Sta	te	31. Date filed (Month, Day, Year)	32: Registrar's	Signature	WON AVE,	INT PICE W	413110	- FAIL	- 10
	Registr	ar	FEB 0 4 2009	flesser &	1. Grank					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2009 JANUARY 29, CONSTANCE NELSON 4:15 P M MARY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1419 Crystal Ridge Ct. Abingdon Harford 8. Date of Birth (Month, Day, Year) Apr. 9, 1914 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🔀 F Months Days Hours Min. Maryland 218-52-3543 94 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County traumatic event, the Medical Examiner must be notified at 1 □Yes 2 No Director Maryland Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21009 USA 1419 Crystal Ridge Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 1 Never Married 2 Married 1 □Yes 2X No Specify: Specify: White If Yes, Give Year or Dates: ģ 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Philomena Vitello 2 Jeremia Mariano 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any Injury or other trau 1419 Crystal Ridge Court, Abingdon, Maryland, 21009 Tom Mariano / Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State TV Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 2/3/2009 Holy Redeemer Cem. Baltimore, Maryland of Fun 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Final Physician 12 years disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Duc to for as a consequence of, Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of deeth 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ੬ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No 24a. Was an autopsy performed? 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \subseteq Nursing Home 5 \overline{\o 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physiclan: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tran Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

within 24 hours after death

To the Funeral Director: ,
completely filled in by the f

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State Registrar

Medical

7505 05

29b. Signature and title of certifier

29a. Certifier

(Check only

and manner stated.

29c. License number 0030122

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30-04

Lawrence J. Snyder, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 308 Towson

31. Date filed (Month, Day, 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1 - State Registrar	State of Ma	aryiand / De <i>C</i>	ertificate of l		Re	g. No.2009	03022				
Di	·	1. Decedent's Name (First, M.		1 11-			2. Date of Death Month		3. Time of Death				
Physic /Medi	cal	mildred		Laughlin	4b City Town or	Location of Death	Jan	3 2 209 4c. County of Deat					
Exami	ner	4a. Facility Name (If not instituted to the company)		ospital	000.	tra		1	County				
Funeral Director		5. Social Security Number 110–16–2785		ge (In yrs. last birthda 88 Yrs	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, MAR 24,	9. Birr 920 New	thplace (State or Foreign York				
w w		Usual Residence of Decedent 10a. State 10b. Cou		10c. City, Town or	Location				10d. Inside City Limits				
Maryla -f sho	ţ		ce Georges	Laurel					1 □Yes 2X No				
th the or 28a	Direc	10e. Street and Number		.l <u> </u>	10f. Zip Code			g. Citizen of What Co	ountry?				
s 23a	Funeral Director	7700 Cherry La	ane, Apt 318	Ever in U.S. 1	20707 3. Was Decedent of H	lispanic Origin? (Sp	ecify Yes or No-	14. Race - Ame	erican Indian,				
or item	Fun	11. Marital Status 1 ☐ Never Married 2 ☐ I	Armed Forces?	No	 Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No 	an, Mexican, Puerto Specify:	Rican, etc.)	Black, White	e, etc.				
ural",	od by	3 Widowed 4 □ Divor	ced Year or Dates:	16a Do	cedent's Usual Occur		1.		Specify: White b. Kind of Business/Industry				
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ed with ygiene yer tha	Com		5+	Soci	al Worker	18. Mother's Name		State Gove	rernment				
d be fill ental H ced oth c even	Be G	17. Father's Name (First, Mid Frederick Newl				Marion Marion		alden durialite)					
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evan, inc., unt be notified an once.	ဥ	19a. Informant's Name/Relat		19b. M 7504	ailing Address (Street Broadclot	and Number or Rui	al Route Number, Lumbia, N	City or Town, State, . 1D 21046	Zip Code)				
is 1 and of Healt item 2		20a. Method of Disposition		20b. Place of Di	sposition (Name of crematory or other place	ce)	Date 2	20c. Location - City or	Town, State				
Page tment tant: If			ion 3 Removal from State er (Specify)		rematory,		09 B	altimore,	MD				
permit Depar Impor any In	ļ	21. Signature of Funeral Ser	vice Licensee C. Todd	Dring	22. Name and Address Cremation	Society (of Maryla	and Inc.					
Cremation Society of Maryland, Inc. 299 Frederick Rd Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
Physician	•	Immediate Cause (Final disease or condition resulting in death)		Onset and Death									
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death ce	Physician/IV	23b. Was decedent pregnamin the past 12 months?	су		Month	23d. Date of delivery Month Day Year							
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d be de				co use contribute to the cause of death? 2 No 3 □ Probably 4 □ Unknown									
ecords, law requires t as been signo	1 Yes 2 An Was an autopsy performed? 1 Yes 2 No								24b. Were autopsy findings available prior to completion of cause of				
The la ate ha page 2) in o						autops perforn 1 □ Yes 2	ned? death?					
VITATICIAN: Tician: Tector, pa		25. Was case referred to medical examiner? Hospital: A Other: Other:											
g Physer this eral dii	12.0	1 Yes 2 No Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death											
sion rending eath. or: After the funer	Catio	1 Natural 5 Pe	vestigation		M 1 🗆]Yes 2□No							
DIVISI	Certification: To	3 ☐ Suicide 6 ☐ Co 4 ☐ Homicide de	28e. Place of Inbuilding, e	28f. Location (Street and Number or Rural Route Number, City or Town, State)									
To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Medical												
To the within To the compl	M												
1		> Whinen		ysician)	V V C	064+9	4	Jan 31,	, 2009				
1		30. Name and address of pe	arson who completed cause of	geath (Item 23a) (Ty	pe, Print) 5 Cedar 1	ane Co	Jumbia,	Jan 31,	14				
	tate	31. Date filed (Month, Day,		trar's Signature									

State Registrar

Amend #26, per Verbal admitting, G888 2/4/09 TT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** 10:24PM M 2009 Augustin Mitchell Prentiss, Jr. January 28, /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Suburban Hospital Montgomery Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1፟፟፟፟ M 2□ F Yrs September 30, 1915 North Carolina Director 224-52-8041 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10b. County 10a State ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Bethesda Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 20817 United States 5600 Wyngate Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 Mo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1937 Baltimore, Maryland 21215-0036 1 ∐Yes 2 🔯 No Specify: ۾ 3 ☐ Widowed 4 ☐ Divorced 1959 White Completed permit. Pages 1 and 2 should be filed within 72 hx Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, Its Medicall once. 16a. Decedent's Usual Occupation 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Colonel U. S. Air Force 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Augustin Mitchell Prentiss, Sr. Anne Hull မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5600 Wyngate Drive Bethesda, Maryland 20817 Corinne Phelps Prentiss/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arlington
National Cemetery 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State April 30, 2009 Rai Cemetery 30, 2009 Arlington, Virginia
22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Bethesda, Maryland 20814-3501 M00335 23a. Part 1. Enter the disease, or com/li-ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Acute Myocardial Infarction disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 □ Yes 2 □ No 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 🖾 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2ŽNo 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only and manner stated. 29d. Date signed (Month. Dav. Year) 29c. License number 29b. Signature and title of certifier , mo marker January 29, 2009 D55779 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hajitha M. Wickramasinghe, M.D. 8600 Old Georgetown Road Bethesda, Maryland 20814
31. Date filed (Month, Day, Year) | 32. Fegistrar's Signature State FEB 04 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Day **Physician** 121,45 EBORAH ANN 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore FRANKLIN Square
5. Social Security Number 6 6. Sex Hospital Cente osedale If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1□ M 2 🕶 F Days Months 216.66.3794 Usual Residence of Decedent MICHIGAN Director JULY 15,1955 10d. Inside City Limits 10a. State 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 2 Yes 2 □ No MD ALTIMORE Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5:4 21 ROAD ANDSDALE Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☑No Specify. Specify: WHITE Be Completed by 3 ☐ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) TOO D WAITRESS 2 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) WALCOTT EERY ATIMAUE SCHLEVING 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print MELLSSA DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place)

Ardent Cremation Syc Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any Injury or o once. 02/01/200 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hanover, 4 □ Donation 5 □ Other (Specify) 22 Name, and Address of Facility Ardent Cremation 7522 Connelley 21. Signature Funeral & rvice Liven ee 21076 MD Hanover, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Day neumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi M betes Q Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ yes 2 ☐ No Month Year Dav 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a 9 I Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown After this certificate has been s funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 M No 1 ☐ Yes 2 ☐ No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2X No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the I 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Two Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier o complete cause of wath (It m 23a) (Type, Print) 30. Name and ddress f pel

State Registrar PODE

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours a To the Funeral I completely

M800341594

rice Thomas 11 Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

Mohammad Afzal M.D 31. Date filed (Month, Day, Year)

29b. Signature and title of certified

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

500 Upper Chesapeake Dr., Bel Air, MD 21014

32. Registrar's Signature

Carks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Robert Lawrence Picard Sr 150 PM Janyar 31 2009 /Medical Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Harford Havre de Grace lursing Honu If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 1/5/1931 9. Birthplace (State or Foreign Country) Social Security Number 1. Age (In yrs. last birthday) **Funeral** Days 158-22-6560 1 X M 2 □ F 78 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at MD Baltimore Parkville Director 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2817 Linganore Ave 21234 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No ģ Specify.White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Salesman Retail permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wilfred Picard Gertrude Boyle 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Picard/Wife 2817 Linganore Ave, Baltimore, MD 21234 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 2/4/2009 | Beltsville, MD Chesapeake Crem. 21. Signature of Funeral Service Licensee < 22. Name and Address of Facility CAFA/Stephen D Lohrmann P.A. M01443 8717 Green Pastures Dr, Towson, MD, 21286 23a. Part1. Errier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Acudom Immediate Cause (Final disease or condition resulting in death) Cerebro Valendar **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last death certificate be executed burial-trar Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by Delindration 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page 2 autopsy performe Vital Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Juliursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To Division or 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation To the Hospital or Attendil within 24 hours after death.
To the Funeral Director: A completely filled in by the fu 1 Yes 2 No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1) 32609 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Kammalm Musam Ho

32. Registrar's Signature

1186 Ravelulion St Hambe Grace

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 101.38 PM 2009 AILEEN C. DELLA PENNA 01 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Franklin Square Hospital Baltimore Center Koseda Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex Social Security Number Months Days Hours 1 □ M 2 🕅 F 219-18-2487 MARYLAND NOV. 29,1925 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐Yes 2 No BALTIMORE MARYLAND MIDDLE RIVER 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code APT. 407 21220 U.S.A. 705 COMPASS ROAD 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ◯XNo Specify. Specify: 3 Widowed 4 □ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BALTIMORE CITY 12TH. GRADE TEACHER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) LAGNESE ANGELINA PASQUALONE FRANK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 112 COVERED WAGON RD. MIDDLE RIVER MD 21220 NANCY_DELLA PENNA/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2/2/2009 BALTIMORE MD HOLY REDEEMER CEM. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee MILLER-DIPPEL FUNERAL HOME, 6415 BELAIR ROAD BALTIMORE 21206 2 a. P. rt1. Enter the disease, or complication that carried the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Spontaneou immediate Cause (Final Intracrania disease or condition resulting in death) lie to (or as a consequence of): Se uential list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) ementio Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an 1∐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760,

law requires that the death certificate be executed attending physician and ned by the a s been signe should be d has certificate or Attending Physician: this After death. within 24 hours after death To the Funeral Director: Hospital

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Examiner

Physician/Medical

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Medical Certification: To

29a. Certifier

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(Check only one)

29b. Signature and title of certifie

30. Name and address of per

Funeral

Director

27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturar", or items 23a any injury or other traumatic event, the Medical Examiner myst once.

Physician

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Examiner

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page 2

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son who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

🗽 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

2000

Itimore Md 21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician Noah Osborne Rill 2009 8:20 A February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll County Carroll Hospital Center Westminster If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Mar. 27 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex 1**X** M 2 □ F 5. Social Security Number , 1922 Maryland Days **Funeral** Months 86 265-38-3608 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h County 10a State d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be multihed at 1 ☐Yes 2 X No Hampstead Carroll County Maryland Director 10f. Zip Code 10g, Citizen of What Country? 21074 United States 1615 North Main Street Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status was becedent ever in o.s. Armed Forces? 1 Xiyes 2 □ No WW II If Yes, Give Year or Dates: permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, Ite Medical Examination. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🕱 No Specify: white Baltimore, Maryland 21215-0036 δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) electrical & College (1-4or 5+) Elementary/Secondary (0-12) electrician & plumber plumbing work 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Treva V. Stoffle Walter J. Rill 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1615 North Main Street Hampstead, Maryland 21074 Wanda Martin Rill - wife Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Feb. 5, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Hampstead, Maryland Shiloh U. M. Cemetery 2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Eline Funeral Home 21. Signature of Funeral Service Linesee 934 South Main Street Hampstead, Maryland 21074 M01072 urv Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician mmediate /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) physician are the burial-t Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) by the a 9 I Inknown 9 Unknown ģ s been signed b should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an as 2 s autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate completely filled in by the funeral director, page 2 🗆 No 1 Yes 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 R/Outpatient 3 DOA မ 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier

29b. Signature and title of certifie

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ompleted cause of death (Item 23a) (Type, Print) M.D

32. Registrar's Signatur

29c. License number

29d. Date signed (Month, Day, Year)

Rosalie Marie Ro		I- For State	ate o	of Maryla		artment of rtificate of		and	Menta	al Hyg		Reg. N	. 200	9	0:	302	
Physicia	an/	Registrar 1. Deœdent's Name (First, Midd	strar cedent's Name (First, Middle,Last)							100	2. Date of Death 3. Time of Death						
Medical Examir		Rosalie Marie Rosetti January 24, 2009 1059 hrs												<u></u>			
		4a. Facility Name (if not instituti 5012 38th Avenue	on, give	street and nun	nber)	4	Hyatts\		ocation of	Death			Prince Geor				
Funeral		5. Social Security Number	6. Sex	Sex 7. Age (In yrs. last birthday)			If Under 1 Year If Under 24Hrs Months Days Hours Min.			24Hrs. Min.				9. Birthplace (State or Foreign			
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5-0036 iled within 7 Hygiene. I other than	ompleted	17. Father's Name (First, Middle		5+		Teache	r & T			Name (First Middle	- Main	Education Surname)	on			
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2121 ould be fil I Mental I s marked ic event,	To B	Daniel Joseph Rosetti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)															
MD nd 2 sho alth and m 27 is		Daniel L. Rose	etti	/ Bro	ther	18401 Place of Disposi					lney,		aryland Oc. Location - City				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other tranmatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 X Crematic	on 3	Removal fro	om State	crematory or oth	er place)			Janu	ary 31					- m J	
timent rtant:		4 Dollation 5 Other Specify.							009		Bethesda						
Bal permi Depai Impo		MO0896 7557 Wisconsin Ave., Bethesda, MD									da, MD 2	vy (2081	Thase,	01			
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Diphennydramine intoxication complicating bronic. Approximate Interval Between Onset and															
/Medical caminer		Immediate Cause (Final disease a obstructive pulmonary disease condition resulting in death)															
		or condition resulting in death) Due to (or as a consequence of):															
	ner	if any, leading to immediate Due to (or as a consequence of):															
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):															
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Division of Vital Records, P.O. Box 6876C Hospital or Attending Physician: The law requires that the death certificate 24 hours after death. Funeral Director: After this certificate has been signed by the attending physicibit filled in by the funeral director, page 2 should be detached for use as the b	Physician/M	IF FEMALE: 23b. Was decedent pregnant in past 12 months?	the	23c. If yes, of 1 Live b	outcome of pre irth		tal death	3	Ectopic	pregnar	ю		23d. Date of deli Month	Day	,	Year	
Box 6 e death cer the attendi ed for use	sicia	4 Pregnant at time of death 5 Other (Specify) g Unknown															
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P.C. res that signed be deta	d by										1	Yes	2 🗸 No 3	Probab	oly 4l	Jnknown	
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of Vitaling Physician: After this certi	2	O 1 V Yes 2 No Impatient 2 ER/Outpatient 3 DOA 4 Nursing name 5 Residence of Culter. Scene									cene						
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Division tal or Attendii rs after death. al Director: /	Certification:	Accident Suicide Fd 1/24/09 Fd 10:51 am Suicide Solution of Suicid															
Divi Hospital or , 24 hours after Funeral Dir tely filled in I	Certi	4 Homicide determined (Specify) Fnd: outside of residence Hyattsville, MD															
To the Host within 24 ho To the Fun completely		29a. Certifier (Check only one) To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)															
To tl withi To tl	Medical	and manner stated. 29b. Signature and title of certifier 29c. License number 29c.							29d. Date signed (Month, Day, Year)								
		O.C.M.E.								January 25, 2009							
1141		30. Name and address of pers															
4,1		Margarita Korell MD			dical Exami		enn Stre	et, Ba	altimore	, MD 2	21201						
St	tate			32. Re	egistrar's Signa	ture											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician Henry Joseph Roth JANUARY 282009 /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A AGNES HOSPITAL 8. Date of Birth (Month, Day, Year) MAR 16 1922 9. Birthplace (State or Foreign (In vrs. last birthday. Social Security Number **Funeral** Days 86 Hours 1**X** M 2□ F 213-20-8656 Maryland Director Usual Residence of Decedent with the Maryland 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 1 ☐ Yes 2X No notified Director MD Baltimore Catonsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or Items 23a or 1529 Park Grove Avenue 21228 USA Funeral 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. s 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Item 27 Is marked other than "natural", or Iter event, the Medical Examiner t Yes 2 No If Yes, Give Year or Dates WWII 1 Never Married 2 Married 1 ☐ Yes 2 ☐No 3altimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Higher Education Accountant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Conrad Roth Helen Justine Clark Harry 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1529 Park Grove Avenue, Catonsville, MD 21228 Mary Ann Roth - wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of h Important: If ite any Injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral Cemeter 02/03/2009 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee H. Williams MacNabb Funeral Home, P.A. Ku le 301 Frederick Road, Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death PROBABLE ACUTE MYOCARDIAL ISCHEMIA Immediate Cause (Final Physician DAY disease or condition resulting in death) /Medical Due to (or as a consequence of): SEVERE CORONARY ATHEROSCLE ROSIS **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ATHEROSCLEROTIC CARDIOVASCULAR DISEASE SEVERE 4 FARS Due to (or as a consequence of): O. Box 68760 Completed by Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Vear for in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ORGANIZING THROMBUS. LEFT INTERNAL CAROTTO ARTELY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 PUnknown Were autopsy findings available prior to completion of cause of 24a. W*a*s an autopsy performed? death? 2□ No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

the Hospital or Attending Physiclan: A O A Division or Awithin 24 hours a To the Funeral L

29c. License number 00037359 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900 CATON AVE BALTIMORE MO 21229

31. Date filed (Month, Day, Year) State

29b. Signature and title of certifier

32. Registrar's Signature 04

Registrar

15+1

Physician

/Medical

Examiner

Funeral

Director

28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ith Medical Examine Interest to notified at

Physician /Medical Examiner burial-transi

attending physician for use as the buria has certificate funeral Hospital or Attending P 24 hours after death. Funeral Director: After t After t the filled in by 24 hours a

P.O. 1

Division of Vital Records,

State of Maryland / Department of Health and Mental Hygiene 2 [] [] 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month 13:52 M Celia B. Saunders January 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOSPITAL UF BALTIMORE BALTIMORE Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Date of Birth (Month, Day, Year) Days 1 □ M 2 □ F Sep 15, 1920 No. Carolina 243-16-5165 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1X Yes 2 □ No Director **Baltimore** N/A Marvland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number IISA 21215 2500 west Belvedere Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Tes 2 No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: þ Black 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **General Services** Social Security 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Vivian Best Ben Best ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3827 Lewin Avenue Baltimore, Maryland 21215 Retha Jackson 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 02/02/09 Laurel, Maryland Maryland National Park Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217

Shock, or heart failure. List only one cause on each line.

ediate Cause (Final Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS lewday Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Et le discripting Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Hypoglycemia 1 ☐Yes a☐No 1 □Yes 25. Was case refer to medical examiner? Be 26. Place of Death (Check only one) Hospital: Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 212No 1 Tes Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Lawi (Ka)nt RES OOC MO 1/28/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SINAI HOSPITAL 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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To the I within 24

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death Rea. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 200 9 Month Day 11:35 PM **Physician** bhary JAMES AUGUST SEGRIST 31 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE CITY BALTIMORE KESWICK HOME If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Jan. 19,1914 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Months **X** M 2 □ F Maryland 215-10-7760 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County d 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene. It hand Mental Hygiene. 77 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 □ Yes 2√YNo Baltimore County Director Marvland Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA 134 Lyndale AVenue 21236 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White 3altimore, Maryland 21215-0036 1 ☐ Yes 2021 No Specify à **3℃**Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 yrs. N/A Tavern Owner Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Segrist Barbara Klecka ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is n any injury or other traun once. 2912 St. Paul St. Baltimore, Md. 21218 Barbara S. Talbot (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State XX Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cem: 2-4-2009 Baltimore, Md. 4 □ Donation 5 □ Other (Specify) 21. For at we of Funeral Service-Licensee ^{22. Name and Address of Facility} Lassahn Funeral Home 7401 Belair Rd. Baltimore, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Vascular dementer Physician e Over /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit Division or Vital Records, P.O. Box 68760, Due to (or as a consequence of): physician Physician/Medical the attending ph for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by atheroseleratic condiduancular 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Chronic read 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an cate has to page 2 sl autopsy perform 1∐ Yes the Hospital or Attending Physician; funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 watural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A
completely filled in by the fi 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number February 2, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , 700 W YOK STREET, BOLTIMERE, MD 21211 MOEGREGOR 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 04

Registrar

13 MARION

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 9:10 PM M 01 2009 Genevieve Barbara Schrenker /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Young at Heart Assisted Living Maryland Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number Age (In yrs. last birthday) Funeral 1 ☐ M 2 🔀 F Months 88 12/31/1920 Maryland 215-42-0321 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r 28a-f show notified at 1 ☐ Yes 2X No Director Baldwin MD Baltimore the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? rai", or Items 23a or Examiner must be r death with 13307 Tyla Lane 21013 U.S.A. Funeral Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 Specify. ģ 3 XWidowed 4 ☐ Divorced "naturai" Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry marked other than "natu matic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaking Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ Martin E. Spangler Elizabeth Burke 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) .00 727 Joppa Farm Road - Joppa, 27 Genevieve Beares (daughter) Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages: Department of IImportant; if ite any injury or ot once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 02/02/2009 | Baltimore, Maryland Parkwood Cemetery 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licensee 60 11750 Belair Road - Kingsville, Maryland ass 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final NEIMONIA **Physician** disease or condition resulting in death) /Medical Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 morths? Month Day Year 5 ☐ Other (specify) the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 1 No 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) ASSIS16P Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No မ this 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After (Month, Day Year) Injury 5 Pending investigation 1 □ Yes 2 □ No death. 2 Accident after death Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) 6 ☐ Could not be 3 ☐ Suicide determined 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed To the Hospital within 24 hours a To the Funeral L

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State

29b. Signature and titte of certifie

29c. License number DØØ 16389

1 Lectrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1716 HAR PORD ROAD SU. 105 FMLSTONIE

PERFECTO C 31. Date filed (Month, Day, Year) 4

Registrar

Medical

29a, Certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2009 7:30 P January Charles Smelser, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick 14101 New Windsor Road Union Bridge If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Months Hours 1 X M 2 □ F Yrs. July 4, 1920 Maryland 88 Director 214-12-9634 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Examples in 11st be mortified at 28a-f show 1 □Yes 2 XNo Directo Union Bridge Maryland Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with innent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or inny or other traumatic event, the Madical Evantial Land 21791 U.S.A 14101 New Windsor Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 1943–59 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) state Elementary/Secondary (0-12) College (1-4or 5+) farmer/politician/president dairy/ rep./banking 11 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles H. Smelser Sr. Grace Devilbiss ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Betty K. Smelser/ wife 14101 New Windsor Rd. Union Bridge, MD 21791 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of F
Important: If ite
any injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Olivet Cemetery 1/2/2009 Frederick, MD 21. Signature of Puneral Service Lice 22. Name and Address of Facility Hartzler Funeral Home athanine 11802 Liberty Rd. Libertytown, MD 21762 23a. Part 1. Enter the disease, or complications that exused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 8107-1124/09 **Physician** olorecta disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be execu and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending physic IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 Yes 2 No 3 Probably 4 Minknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 ☐Yes 2 ☐ No 1 □Yes 2 No Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2 3 N 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Vitural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 refritiying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated

29b. Signature and title of certifier

30 Name and address of person who completed cause of

32. Registrar's S

State Registrar

DHMH 17 Rev 1/2001

Los Street (Worthwister MD 2115)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** JANUARY 30 2009 11:50 PM Ferdinand N. Snyder /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HARFORD BELATE 1+2
5. Social Security Number HEALTH AND REHAB CENT If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 12-23-1914 Birthplace (State or Foreign Country) **Funeral** Days 1 🔀 M 2 🗆 F Hours NJ 156-09-7929 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County 28a-f show be notified at 1 ☐ Yes 2 No Director Harford Bel Air MT the ! 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5 USA 21014 292 G. Canterbury Rd items 23a death v Funeral 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examinar 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Accountant Accounting 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Agnes Fritz Adam Snyder ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 292 G. Canterbury Rd Bel Air, MD 21014 Rena Taddeo (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory 02-02-2009 Baltimore, MD 5 ☐ Other (Specify) 4 □ Donation 22. Name and Address of Facility Signature of Funeral Service Licensee Inc. 610 W. MacPhail Rd Bel Air, MD 21014 BelAir Approximate Interval Between Onset and Death 23a. P.m.1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause of each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final 1 Mm **Physician** disease or condition resulting in death) /Medical a consequence of) Examiner commun Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed P.O. Box 68760, A Due to (or as a consequence of) Physician/Medical 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 2 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Auer uns certificate has been signed in funeral director, page 2 should be det Vital Records. 3 4 V Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? yes 2 No 2 No 1 ☐ Yes 1∐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Hospital: Other: 1 ☐ Yes 2 Mo 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Wursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To o 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) þ 4 Homicide within 24 hours a i 🗡 Certifylng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examines: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner sta 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H

State Registrar 31. Date filed (Month, Day, Year)

FERDINAND

32. Registrar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 03036 1 - State Registrar Reg. No 2 1 1 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death JANUARY 14:42 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death NA JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE 8. Date of Birth (Month, Day, Year) 8-20-1927 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours Min 1 ☐ M 2 🖫 F 81 266-36-5467 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10h County 10c. City, Town or Location 1 Yes 2 □ No MD N/A Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 1119 N. Luzerne Avenue 21213 US Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2√∑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: Specify: Black 3 ₩ Widowed 4 Divorced 16a Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nurse Assistant GBMC 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unk Walter Kilby 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Marquis Spencer-Son 1119 N. Luzerne Avenue Balto, MD 21213 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park 2/7/2009 Balto, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H 1101 E. (North Avenue Balto, MD 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RESPIRATORY Due to (or as a consequence of): DISSEMINATED INTRAVASCULAR COAGULATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 ☐Yes 2 ☑No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital:

Physician /Medical Examiner

be executed

requires that the death certificate

Box 68760,

P.O.

Division of Vital Records,

Physician

Examiner

Funeral

Director

28a-f show

6 death with

23a

items ?

6

"natural"

Hygiene.

is marked other

Health a

Department of Health Important: If item 27 any Injury or other tr

Pages 1 and 2 should be

traumatic event, the Modical Examiner must be notified

Director

Funeral

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Completed

the Maryland

72 hours after

Baltimore, Maryland 21215-0036

/Medical

Examiner Physician/Medical þ

Completed

burial-transi attending physician the use as ō the a detached sate has been signed by page 2 should be detach certificate has Il or Attending Physician: after death. Director: After this certifica funeral director, Be Certification: To filled in by the

To the Hospital of within 24 hours at To the Funeral D State IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

2 🗆 No

5 Pending

investigation

6 Could not be determined

1 Yes

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

Medical

4 Homicide

(Check only one)

29b. Signature and title of certifier

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28c. Injury at Work? 1 ☐ Yes 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MIJOURH 31. Date filed (Month, Day, Year)

32. Registrar's Signature

1 Inpatient

28a. Date of Injury (Month, Day, Year)

and manner stated.

Registra

2 ER/Outpatient 3 DOA

28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

09-00905 Ronald Saunders

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		- For State Certificate of Death	Mental Hyg	Reg. N	. 200	9 03031
Physicia	n/	1. Decedent's Name (First, Middle,Last)		Date of Death Month Day	/ Year	3. Time of Death 0000 hrs
ledical Examin		Ronald Wayne Saunders Sr. 4a Escility Name (if not institution give street and number) 4b. City, Town, or Lo		January 31, 2	009 4c. County of Death	
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Lo Towson			Baltimore Cou	unty
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year		B. Date of Birth (M	M/DD/YYYY) 9. Bir Forei	an l
Director		230-56-5457 1X M 2 F 64 Yrs. Months Days	Hours Min.	Jan. 12,	1945 cd	ountry) Virginia
any	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			· · · · · · · · · · · · · · · · · · ·	10d. Inside City Limits
*	_ 1	Maryland Harford Abingdon				1 Yes 2 X No
Maryland 28a-f show d at once,	Director	10e. Street and Number 10f. Zip Code		10g. 0	Citizen of What Cou	intry?
the N	5	4050 Sharilynn Drive 21009			USA	
by MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland lealth and Mental Hygiene. tren 27 is marked other than "natural", or items 23a or 28a-f she transmatic event, the Medical Examiner must be notified at ouce	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispa 14. Never Married 2 Married Armed Forces? 15. Was Decedent of Hispa 16. If Yes, specify Cuban, Married Proces?	anic Origin? (Spec Mexican, Puerto Ri	ify Yes or No- can, etc.)	14. Race - Amer White, etc.	rican Indian, Black,
er dea		1 Yes 2 X No 3 Widowed 4 X Divorced If Yes, Give Year 1 Yes 2 X No	specify:		Specify: US	A
urs aft tural"	핡	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation	n (Give kind of wor		o. Kind of Business	
72 hor "na	eted	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. D	O NOT use retired	1)		
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21215-0036 Buld be filed within 72 Mental Hygiene. marked other than c event, the Medical	To Be	Charlie Lee Saunders Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street a				e, Zip Code)
MD d 2 sho Ith and n 27 is		Ronald W. Saunders Jr. / Son 3512 Donegal				
Te, I and I and Healt Fitem	Ī	20a. Method of Disposition 20b. Place of Disposition (Name of ceme crematory or other place)	etery, I	Date 20	c. Location - City o	r Town, State
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Baltimore, MD 21215 permit. Pages I and 2 should be file Department of Health and Mental It Important: If iten 27 is marked o injury or other traumatic event, th		21. Signature of Juneral Service Licensee 22. Name and Address of	1.100		neral Hom	
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Physician // // // // // // // // // // // // //		failure. List only one cause or each line.				Between Onset and Death
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7	- 1	or condition resulting in death) Due to (or as a consequence of):				
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	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause				_
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			For State Registrar	State of	Maryland		artment of H		d Mental Hy	giene Reg. No 20	0.9	03038
-			Decedent's Name (First, Middle,	Last)					2. Date of Dea	ath		3. Time of Death
0	Physici /Medic		Billy Raymond	Shupe Sr.					Janua	Day	Year 2009	10:20 AM
	Examin		4a. Facility Name (If not institution,	give street and num	nber)		4b. City, Town, or	Location of D			y of Death	
الصر			Bel Pre Nursin	g & Rehab	. Center	r		Silve	r Spring	Mon	tgomer	TV.
	Funeral		5. Social Security Number		7. Age (In yrs. las		If Under 1 Year Months Days	If Under 24		h		lace (State or Foreign
di-	Director		216-48-9312	1 ⊠ M 2□F	59	Yrs.	menate Baye	Tiodis I		/1949	VA	
	pu »		Usual Residence of Decedent 10a. State 10b. County		10c City	Town or Lo	cation				- 4	Od Incide City Limite
	sho sho	<u>ا</u> م									''	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	he M	Director		gomery	Sil	lver :	Spring					
	with the period		10e. Street and Number				10f. Zip Code			10g. Citizen of	What Coun	try?
	s 23s	Funeral	2601 Bel Pre R		de at Francis III o	140	20906-		0.40		d Sta	
	er de Item	i.	11. Marital Status 1 Never Married 2 Married Married	Armed For		. 13.	was Decedent of Hi If Yes, specify Cuba	ispanic Origin in, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)	Bla	ce - America ck, White,	
36	rs af	b	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	e		1 ☐ Yes 2 ☑ No	Specify:		Speci		
21215-0036	72 hours after death with the Maryland 'natural'; or Items 23a or 28a-f show diral Examiner must be notified at		15. Decedent			16a. Dece	dent's Usual Occupa	ation	- 1	16b. Kind of E	Whi Business/Inc	
15	- " 6	Completed	(Specify only highes: Elementary/Secondary (0-12)	t grade completed) College (1-	40151)	(Give life.	kind of work done o DO NOT use retired	furing most of)	working		ructio	·
212	filed within Hygiene. other than " ent, the Me	E	8	College (1-	-401 54)	Carr	enter				_ 4001	
	be filed within 72 hours after death with the Marylan stal Hygiene. Ed other than "natural", or Items 23a or 28a-f show other than "natural", or Items 23a or 20a-f show event, the Medical Examiner must be notifiled at	Be C	17. Father's Name (First, Middle, L	ast)		•		18. Mother's	Name (First, Middle,	Maiden Surna	me)	-
Maryland	2 should be filed withir and Mental Hygiene. is marked other than aumatic event, the Me	TO E	Rex Shupe					Virg	inia Rober	ts		
ary	s 1 and 2 should F Health and Mer Item 27 is marke other traumatic		19a. Informant's Name/Relationsh	ip (Type. Print)		19b. Mailir	ng Address (Street a	and Number o	or Rural Route Numbe	er, City or Town	, State, Zip	Code)
	# 23 ≡ 4		John Shupe/Son			801	6 Joetta	Dr. El	kridge, MI	21075	_	
re	ges 1 ar t of Hea if Item or other		20a. Method of Disposition		1 001	ce of Dispo	sition (Name of matory or other plac	e)	Date	20c. Location	- City or To	wn, State
E	Page nent o int: # iry or		1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (Sp		state		ake Crema	1	Feb 4 2009	Beltsv	rille.	Maryland
Baltimore,	permit. Pages 1 Department of F Important: If Ite any Injury or ot once.		21. Signature of Funeral Service L	jc@nseg	m0038		2. Name and Address		2009		0.28	838
Ω	8 9 E E 8		Thole DX	Here an	u-	~			remation Se ilver Sprin			0010
			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that ca	aused the death.	Do not ent	er the mode of dyin	g, such as car	rdiac or respiratory ar	rest,	Land 2	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		FRIA	1 -	PIBKI	LLA	TION			Onset and Death
	/Medical		resulting in death)	a. Due to (or as conseque	ence of):	() ()	. 0		0	-	
	Examiner		Convention to the constitues	h C	EKE15	ROI	ASCUL	AK :	ACCIDE	N7.		
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (d	or as a conseque	ence of):						
	ecute nd trans	Examiner	that initiated events	с								
0,	e exe ian a urial-	Ĭ	resulting in death) Last	Due to (or as a conseque	ence of):						
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	lical		d								
9	ertifica ing ph e as t	Physician/Med	IF FEMALE:									
Вох	leath certific attending p for use as	an/	23b. Was decedent pregnant in the past 12 months?		come pf pregnand irth 2 □ Fetal c		∃Ectopic pregnancy			-	ate of delive	,
-	the a	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregna 9☐Unkno	ant at time of dea	ath 5	Other (specify)			l IV	onth	Day Year
P.0	res that the de signed by the a be detached f	P	Part II. Other significant conditio	no contributing to do	ath but not recult	ing in the c	ndaduina asusa siya	on in Doct I	OO - Did to		A-21- A - A - A1-	
S,	ires ti signe	þ	Fatt II. Other Significant conditio	ns contributing to de	atii but not result	ing in the u	ndenying cause give	en in Part I.				e cause of death?
Records,	w requir been si should	Completed	τ						_ ''''	′es 2 No	3 ☐ Prob	ably 4 Unknown
ec	e law has b je 2 si	ld l					<u> </u>		— 24a. Was autop	ev/	Were autor	osy findings available npletion of cause of
F	The cate I	ပ္ပြ							perfo	med? 20 No	death? 1 ☐ Yes	2 □ No
Vital	Physician: this certifica	Be	25. Was case referred to medical examiner?	11			la.	- N	Death (Check only o	ne)		
ō	this a	은	1 Yes 2 No			R/Outpatier		#L Nursir	ng Home 5 ☐ Resid)
	Ing After	Certification:	27. Manner of Death Natural 5 ☐ Pending		h, Day Year)	28b. Time o Injury	Work	(?	28d. Describe h	ow injury occu	rred	
Si	Attending r death. ector: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could n	ot be 290 Place	of injuny - At hom	o form of	M 1□' eet, factory, office	Yes 2 □ No	201 1 1 1 1			
Division	or Attendafter death Director: in by the	Ħ	4 Homicide determine	ned buildir	ng, etc. (Specify)	ie, iaiii, sii	eet, factory, office		City or Tow	n, State)	ber or Hura	l Route Number,
_	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: / completely filled in by the fi		29a. Certifier	Physician: To the	hest of my knowl	ledge don*	h occurred at the time	no dato on d	place, and due to the	201100(0)	000000000000000000000000000000000000000	atod
	24 hg 24 hg Fun etely	Medical	(Check only 2 Medical E	xaminer: On the ba	asis of examination	on and/or in	vestigation, in my o	pinion, death	occurred at the time,	date and place	, and due to	the cause(s)
	o the	Me	29b. Signature and title of certifier	and main			29¢ License	e number		29d. Date sign	ed (Month.)	Day, Year)
	► > ⊢ ō		· Manha	ne		M.	DI DIG	7312	ζ	1/2	DIN	9
_			30. Name and address of person v	who completed care	enf death /lt-	(Tree	Print)	1		110	70	1
	2 VT		O. Name and address of person (VE Caus	1055	Cher	repolet	Avil	re, El	licot	t Ceto	721045
	Sta Registi		31. Date filed (Month, Day, Year)	09 A32. Re	egistrar's Signatu	par	les .		/			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician John Thomas Smith January /Medical 4b City, Town, or Location of Doath 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore N/A If Under 1 Year | If Under 24 Hrs Social Security Number ge (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) July 15,1931 Birthplace (State or Foreign Country) **Funeral** Days Hours 1**X**☐M 2□F 229-36-7618 **Director** Virginia Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 No Director Baltimore Catonsville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 428 Bloomsbury Avenue 21228 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 No ۵ م 3√ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Plumber Plumbing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John R. Smith Annie Bradds ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fred W. Smith, Brother <u>428 Bloomsbury Avenue Catonsville, Maryland 21228</u> 20b. Place of Disposition (Name of cemetery, crematory or other Goshen Baptist Church Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 02/02/09 4 ☐ Donation 5 ☐ Other (Specify) Goshen, Virginia 21. Signature of Funeral Service Longse MacNabb funeral Home, P.A. 301 Frederick Road Catonsville, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 140 cardrai **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed the burial-tran Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of certificate death? 1 ☐ Yes 2 □ No Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 1 D Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending investigation Injury 1 🗌 Yes death. 2 □ No 2 Accident **Director**: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 28/2004

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

		•	For State Registrar		State of M	aryland		rtment of F tificate of	lealth and I Death	•	_	2009	0	3040
	Physici		1. Decedent's Name Vera G. T		t)					2. Date of Dea Month	Da			ime of Death
	/Medic Examin Funeral	er	4a. Facility Name (If I	Hospital		ge (In yrs. las	st birthday)		r Location of Death 11Stown 1 If Under 24 Hrs.)	40	County of Dea Baltin	nore	
l.	Director		157-66-4237 Usual Residence of D		□ M 24 F	96	Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Da 0-20-19	12 Year,	Ja	ountry)	State or Foreign
	aryland show	<u>-</u>	10a. State	10b. County		10c. City,	Town or Lo		•					side City Limits
	r 28a-f	irecto	MD 10e. Street and Numi	Baltim	ore	<u> </u>	Owing	S Mills 10f. Zip Code			10g. Ci	itizen of What Co]Yes 2∏No
	s 23a o	Funeral Director	4734 Avata	er Lane	40 W D I	- · · · · ·	1.0.1	2111				USA		
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Medical Examples to inciting a once.	þ	11. Marital Status 1 □ Never Marrier 3 ☒ Widowed 4		12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No	1	Was Decedent of F f Yes, specify Cub I □ Yes 2 XNo	dispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		14. Race - Ame Black, Whit	erican Indi e, etc. Janaic	
15-0	in 72 ho n "natu Nedical	Completed		15. Decedent's Edi y only highest grad			16a. Deced (Give life. L	dent's Usual Occup kind of work done OO NOT use retire	nation during most of wor d)	king	16b. k	Kind of Business	/Industry	
1212	led with Hygiene her tha nt, II e I	Com	Elementary/Second		College (1-4or	0+)	Fa	amer	10 Mather's Non	os /First Middle		elf-Employ	yed	
lanc	uld be fi dental H rked ot tic ever	To Be	17. Father's Name (F Benjanin Boo						18. Mother's Nan Jenmah	n Henry	iviaiuei	i Sumame)		
Baltimore, Maryland 21215-0036	d 2 shorth and 1 th and 1 trauma	1 3	19a. Informant's Nam						and Number or Ru		er, City	or Town, State,	Zip Code)	
ore,	es 1 an of Heal fitem 2 rother	1. a	Merie Willi 20a. Method of Dispo	osition		20b. Pla		Watar Lane sition (Name of natory or other pla	, Owings Mi ce)	Date	20c. L	ocation - City or	Town, Sta	ate
Itim	urtment artment ortant: h injury o			5 ☐ Other (Specify	·		Savio	irs Chirch		ary12,2009				
Ba	permi Depar Impor any ir		21. Signaturgor Pull	waa	W 11.1	Myl			Road Rand				·	
	Physician /Medical		23a. Part. Enter the shock, or heart Immediate Cause (F disease or condition resulting in death)	inal		we	Do not ent	er the mode of dyi	ng, such as cardiad	or respiratory a	rrest,		Intervi Onset	oximate ral Between t and Death w
T	Examiner		Sequentially list cond	ditions		neum	1milos						10	DAYS
	cuted nd ransit	Examiner	Sequentially list conditions are cause. Enter Underlicause (Disease or in that initiated events	ying njury	Due to (or as	nehra	s rasu	lar 90	oident				15	0445
68760,	eath certificate be executed attending physician and for use as the burial-transit	edical Exa	resulting in death) La	ast	Due to (or as	a conseque	nce of):	- inteol					15 /	D445
O. Box	The law requires that the death certifik at has been signed by the attending prage 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent print the past 12 mm 1 □ Yes 2 ☑ 9 □ Unknown	nenths?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 🗆 Fetal d	death 3□	Ectopic pregnand Other <i>(specify)</i>	çy			23d. Date of de Month	livery Day	Year
s, P.	es that igned by be deta	by Ph	Part II. Other signific		ontributing to death t			, ,				use contribute to		,
cord	e law requires tha has been signed e 2 should be det	leted	10 (01)	V Meth	700 7 00	(2,71,10)	, Cr	Trend	9-110-11	1 ∐ \ 24a. Was		No 3 P		dings available
∃ Re	The lar	Completed by								autop	osy rmed?	prior to	completio	on of cause of
Vita	sician: s certific lirector,	Be	25. Was case referre examiner? 1 ☐ Yes 2 ☑ ✓	/	Hospital:	iont 2 🗆 E	P/Outpation	nt 3 □ DOA Oth		th (Check only o		€ □ Oth er (O	16.1	
Division of Vital Records,	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	Certification: To	27. Manner of Death 1 ☑ Natural 2 ☐ Accident		28a. Date of Inj (Month, Da	ury 2	28b. Time of Injury	28c. Inju Woi		28d. Describe I			ecity)	
Divis	al or Atte	Sertific	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	20e. Place of In	jury - At hom tc. <i>(Specify)</i>		eet, factory, office		28f. Location (8 City or Tox		nd Number or R le)	ural Route	Number,
	Hospit 24 hour Funera etely fills	Medical (29a. Certifier (Check only one)	Certifying Phy Medical Exam	yslcian: To the best liner: On the basis and manner si	of examination	ledge, deatl on and/or in	n occurred at the t vestigation, in my	ime, date and place opinion, death occu	e, and due to the arred at the time,	cause(date ar	s) and manner and place, and du	s stated. e to the ca	ause(s)
	To the within To the comp	Me	29b. Signature and ti	1	3			29c. Licens				ate signed (Mon.		ear)
	6		30. Name and addre	ss of person who	•	DESH death (Item 2			494	_	az.	- 2-26		
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	Sta Registi		31. Date filed (Month	0 4 2009	32. Hegist			المنا						

VERA TAULOR

State of Maryland / Department of Health and Mental Hygiener 03041 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 200° **Physician** 605 PI M Mary Lou Tiffner anvary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Randallstown Baltimore Seasons Hospice If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) APR 9, 1933 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 ☐ M 2 👿 F 75 219-80-3092 Virginia Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, I'w Madical Examiner must be notified at MD Baltimore X Yes 2□No N/A Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country 21226 USA 1613 Ceddox Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ∐Yes 2 XX If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: þ Specify: 3 ₩ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Dove ၉ James Pearson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 it 770 Southern Hills Drive Arnold, MD 21012 Bonita Tiffner/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State (JO) Department of Important: If it any injury or conce. Metro Crematory, Inc. 2/2/09 Baltimore, MD 21. Signature of Funeral Service Licensee C. Todd Dring 22. Name and Address of Facility
Cremation Society of Maryland, <u>299 Frederick Rd Baltimore, MD 21228</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) END STAGE CARRIOMYOPATHY /Medical Due to (or as a consequence of) Examiner CORENARY ARTERY Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) been signed by the should be detached 1 ☐Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably 4 ♥ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □ No cate has page 2 s autopsy performed: certificate 2 **N**No 1 □Yes after death.

Director: After this certific Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 Homicide To the Hospital 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue Baltimore 31. Date filed (Month, Day, Year) 2. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death edent's Name (First, Middle, Last) **Physician** /Medical institution, give street and Examiner Dice DME Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 🗷 F 5° Director 00/194 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any hjurry or other traumatic event, the Medical Experiment must be neutified at once. 1 Yes 2 □ No Director timore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Tolin, State, Zip Code) rmant's Name/Relationship (Type. Print) 19a. In 20a. Method of Disposition Date 20c. Location Burial 2 Cremation 3 Removal from State Funeral Service License 21. Signature MO155 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Due to or as consequence of): recurrent 420 /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal deat 3 Ectopic pregnancy Month in the past 12 months? Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☑No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 SMAPHYLOCOCCA 2 **20**No Mesune 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 MOther (Specify) Waspile 2 No 1 Yes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 □Yes 2 □ No death. 2 Accident 24 hours after deatle Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar ANLOW J CH

FEB 0 4 2009

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N. Charles

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NO

32. Registrar's Signature

HANBL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 30,2009 **Physician** Gladys M. Wheeler 12:30P M Jan. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 805 Wilbert Avenue Baltimore N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday **Funeral** 8. Date of Birth (Month, Day, Year) Days Months Hours 1 ☐ M 2 🖫 F 215-40-6067 66 Director Feb.15,1942 S.Carolina Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at MD N/A Baltimore Director 1XX es 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 805 Wilbert Avenue 21212 USA "natural", or items 23a permit. Pages 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Evantines must once. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Black Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Social Security Elementary/Secondary (0-12) College (1-4or 5+) Administration 4 years Computer Programmer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Noah Young Leona ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 805 Wilbert Avenue Baltimore, MD 21212 Braxton Wheeler/ Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 2/9/09 Pate 20c. Location - City or Town, State 15 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet. Cem. Owings Mills, MD 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Juneral Service Licenses 4210 Belair Road Baltimore. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** carcinoma Oheyear UNG /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): To the HospItal or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1XYes 2 No 3 Probably 4 Unknown After this certificate has been s funeral director, page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗆 No 1 ☐ Yes 2**X** No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Matural 2 ☐ Accident 5 Pending 1 ☐Yes 2 ☐ No investigation Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records,

State Registrar

Medical

29a. Certifier

(Check only one)

Mansha

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32.

6569

Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

North Charles Street Suite 205 Toloson,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 03044 Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year II:a7AM Kettu Jamesavu 21 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death tospital Randallstown Baltimore ovethi If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) (In vrs. last birthday) Days 1 M 2 X F 65 218-44-4051 10-10-1943 Md Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 √Yes 2 No Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2607 Oswego Ave. 21215 U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 Never Married 2 Married 1 Tes 25 No If Yes, Give Year or Dates: Specify: B<u>lack</u> 1 ☐ Yes 2 ☑ No Specify. 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chimes, Inc Custodian 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Theodore Harrison Gertrude West 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dwayne West / Son Tentmill Lane #d Baltimore, Md 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ₺ Burial 2 □ Cremation 3 □ Removal from State 4- Donation 5 □ Other (Specify) Druid Ridge Cem 11/31/09 Pikesville, Md 21. Signature of Funeral Service Looksee 22. Name and Address of Facility 21215 Chatman-Harris F.H 5240 Reisterstown Rd TAL 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, anock, or hear failure. List only one cause on each line. mediate Cause (Final disease or condition resulting in death) Atherosclerati Due to (or as a consequence of) newtension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of Diabetes Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy

Physician /Medical Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed

Physician

Examiner

Funeral

Director

show

Director

Funeral

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Completed

Be ဂ္ Md

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show important: If item 27 is marked other than "natural", or items 23a or 28a-4 show important: If item 27 is mary injury or other traumatic event; Item Marical Examinational be notified at once.

/Medical

Examine and burial-trai the attending p certificate has been signed by the rector, page 2 should be detached after death.

Director: After this certific

Division of Vital Records, P.O. Box 68760,

Be Completed by Physician/Medical Certification: To

23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3 Ectopic			Month Day Year
Part II. Other significant conditions	contributing to death but not resul	Iting in the underlying	cause given in Part I.		sse contribute to the cause of death? ☐ No 3 ☐ Probably 4 ☐ Unknown
				24a. Was an autopsy performed? 1 □ Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2	ER/Outpatient 3	Othor	eath <i>(Check only one)</i> Home 5 Residence	3 ☐ Other (Specify)
27. Manner of Death 1	(Month, Day, Year) n	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injur	y occurred
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		me, farm, street, facto)	ory, office	28f. Location (Street an City or Town, State	d Number or Rural Route Number,)
	hysician: To the best of my know miner: On the basis of examinat				

State Registrar

within 24 hours aft To the Funeral Di completely filled in

Medical

and manner stated

46055644

29c. License number

29d. Date signed (Month. Day. Year) 2006, 15 presunch

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Randallstown MD 21133 5401 Old Court Rd Yorke

31. Date filed (Month, Day, Year) FEB 0 4 2009

29b. Signatuce and title of certifier

32. Registrar's Signature neur

amend #31 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 28,2009 Physician Geniva Wilkerson Month 12:55A Jan. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore n/a Bayview Medical Center 8. Date of Birth (Month, Day, Year) Feb. 5, 1938 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 □ M 3√□ F 212 58 0114 70 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show ral", or items 23a or 28a-f sho MD n/a Baltimore Yes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 any Injury or other traumatic event, the Medical Examinar must be in once. 21206 4905 Bowland Ave. USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □Yes 2 XNo If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 No δ Specify: Black 3 Widowed 4 ☐ Divorced Year or Dates: Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) line worker Dovers Poultry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ella Marshborne George Thomas Foster ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Georgia Foster (daughter) 4905 Bowland Ave. Balto, Md. 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Zion Cem. Feb. 6, 2009 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License Caivin B. Adstruggs Funeral Home 1412 E. Preston St. Baltimore, Md. 21213 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) monar /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? þ 2 🗌 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2.2.No 2 No 1 Tyes Division of Vital 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Mainpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 💢 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) maldson Avenue 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

Division of Vital Records,

State

Registrar

29b. Signature and title of certifier

Jon K. Minford,

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Pegistrar's Signatur

M.D.

D 30573

11065 Little Patuxent Parkway Columbia, MD 21044

FEBRUARY 2, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Leroy Walker January 30, 2009 11:45 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Kernan Hospital Baltimore N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours JAN 19 1950 1**X** M 2□ F Louisiana 59 435-84-5542 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Baltimore Catonsville 10f. Zip Code **21228** 10e Street and Number 10g. Citizen of What Country? 703 Marianne Lane USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 14. Race - American Indian. 1 Tayes 2 No
If Yes, Give
Year or Dates: UNK 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced **Black** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Stage Hand Entertainment 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) UNK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Donna Jean Goins - fiance 703 Marianne Lane, Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 02/05/2009 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Williams MacNabb Funeral Home, P.A. 301 Frederick Road, Catonsville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACUTE INTHACERENAL Henroman disease or condition resulting in death) Due to (or as a consequence of): WITH GENERALIZARU OMINURY FOLAL STIZULE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): RESPIRATORY Due to (or as a consequence of): 17 SUSTULE 5mmi yes, outcome of pregnancy 23d. Date of delivery 3 Ectopic pregnancy Month Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown CURLUMINOUS HURGZIRWSLV 12/3/08 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 → No いいいかでれをかえる 24a. Was an autopsy performed? 26. Place of Death (Check only one Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner executed and burial-trar

physician

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page 2

certificate

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After 1

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To the Funeral Director; A
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Hospital or Attending

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Box 68760

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Records,

Division of Vital

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

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Completed

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UNK

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

3altimore, Maryland 21215-0036

Physician/Medical ģ Completed

Certification: To

Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

MID

MD

25. Was case referred to medical examiner? 1 ☐ Yes 2 No

27. Manner of Death

4 - Homicide

MICHMIL

1 Natural 2 Accident 5 Pending investigation 3 Suicide

6 Could not be determined

Date of Injury (Month, Day, Year) 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title o ertifier 29c. License number 145101

29d. Date signed (Month, Day, Year) 3 109

410-448-6747

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2000 KERNEN DUVE PALTIMOLE MS 21207 J. MAKLEY

31. Date filed (Month, Day, Year)

32 Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 30, 2009 7:10a CHARLES WILSON SR. **JANUARY** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE N/A 5427 PURDUE AVE. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Davs Months Hours 1 X M 2 □ F Director 70 6-22-1938 VIRGINIA 229**–**48–3721 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Medic I Examinat rougher coffice a Director 1 X Yes 2 □ No MD. BALTIMORE N/A10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5427 PURDUE AVE 21239 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ∐Yes 2 No Specify: Specify: BLACK þ 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) TRANSPORTATION BALTO. HEALTH DEPT. 18. Mother's Name (First, Middle, Maiden Surname) Be (17. Father's Name (First, Middle, Last) ပ REV. BENJAMIN W. WILSON SR. LOUISE C. McDANIELS and Is ma 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau CHARLES WILSON JR. (SON) 5427 PURDUE AVE. BALTIMORE, MARYLAND 21239 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation /5 ☐ Other (Specify) WOODLAWN CEMETERY 12-7-2009 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensed ONATHAN D. HIBNER 2. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Firt V Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, how, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ffuse **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) ed by the 9 Unknown ate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₫ CAD 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Completed HTN 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 □ Yes 2 ☒ No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🖫 Residence 6 Nother (Specify) Hospital: 1 ∐Yes 2 🔣 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28c. Injury at Work? After 1 1 X Natura 5 Pending investigation To the France.

Within 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Deficiency Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and the of certifier "accounded khan 29c. License number 29d. Date signed (Month, Day, Year) 1-30,09 00061272

or Attending Physician; The law requires that the death certificate be executed Box 68760. P.0. Division of Vital Records, Hospital

Baltimore, Maryland 21215-0036

Registrar

31. Date filed (Month, Day, Year) FEB 0 4 2009

SAEEDUDDIN ICHAN.

30. Name all d address of person who completed cause of death (Item 23a) (Type, Print)



M.D.

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SAMARITAN HOSPITAL

		1	State of Maryland / Department of Health 1- State Amend Item 29d per dr., g888, 02/04/09dhb, #1 Certificate of Deat	n and Mental Hy <i>th</i>	rgiene Reg. No 2009 03049
ı	Physicia	an	1. Decedent's Name (First, Middle, Last) Kenneth Zierler	2. Date of De Month JANUAR	Day Year
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location		4c. County of Death
	4		5 Social Security Number 6 Sex 7 Age (In vrs last birthday) If Under 1 Year If Und		N/A rth 9. Birthplace (State or Foreign
	Funeral Director		$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$		1917 Shiftplace (State of Foreign Country)
	yland how	L	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	he Ma 28a-f s	Director	MD BALTIMORE TOWSON 10e. Street and Number 10f. Zip Code		1 ☐ Yes 2 🛣 No
	3a or 3	al Dir	10e. Street and Number 6620 CHARLESWAY 21204		USA
30	d within 72 hours after death with the Maryland glene. Than "natural", or items 23a or 28a-f show The Modical Expriment meet for coffficed at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No Specific Cuban, Mexical Status Section 1 □ Yes 2 □ No Specific Cuban, Mexical S		
5-0036	72 hour natural ileal Ex		15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during m	most of workina	16b. Kind of Business/Industry
121	filed within 7 Hygiene. other than "sent, in c. I'vec	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	SICIAN	HEALTH CARE
andz	Hy othe	Be Co	17. Father's Name (First, Middle, Last) 18. Mo	other's Name (First, Middle	e, Maiden Surname)
\leq		P	JOSEPH ZIERLER	BETSY	LEVY
Mar	7 - 7 -		19a. Informant's Name/Relationship (Type. Print) MICHAEL ZIERLER / SON 2 HENRY COURT, N		
Baltimore,	1 al Heg		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
Ē	permit. Pages Department of Important: If it any injury or o		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Far		REISTERSTOWN, MD INSON & BROS., INC.
g	Department of the permitted of the permi				- PIKESVILLE, MD 21208
ľ	ø		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line.	n as cardiac or respiratory	arrest, Approximate Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):		Jens
	Examiner	L			
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.		
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O. Box	death cert e attendin d for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □		23d. Date of delivery Month Day Year
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Vital Records,	The lar ate has bage 2	Completed	Monic Flany Vistage	perf	s an 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 2 No
VII3	sician certifi irector,	Be	examiner?	Place of Death (Check only	one) sidence 6 □ Other (Specify)
סר	iding Physician; th. After this certific: funeral director, I	n: To	27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) 28b. Time of Injury 28b. Time of Injury Work?		how injury occurred
Division of	ttendir Jeath. tor: Af the fur	icatic	2 Accident investigation M 1 Yes 2		(Street and Number or Rural Route Number,
2	ipital or At ours after d eral Direct filled in by	Certification: To	4 Homicide determined determined building, etc. (Specify)	City or To	own, State)
	To the Hospital or Attending Physician: within 24 bours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, and manner stated.		
	To the vithing comp	Ň	29b. Signature and title of certified 29c. License numb	1	29d. Date signed (Month, Day, Year) January 19, 2009
(1	0		30. Name and oldress of person who completed cause of death (Item 23a) (Type, Print)	1211	
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature—		
	Registi	ar	FEB 0 4 2009 Clertus B. Garrer		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State of Maryland / Department of Health an 1- Registrar Certificate of Death	ia ivientai F	iygien Reg. N	- 2 n n c	03050
	Physicia	an	1. Decedent's Name (First, Middle, Last)	2. Date of Month	Death	ay Year	3. Time of Death
-	/Medic Éxamin	al	1 dense trances Monderson 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of D	Death	/6	c. County of Death	1749 M
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	Funeral Director		5. Social Security Number 216-58-7543 6. Sex 1	Min. Aug.	Birth Day Year	1953 Mar	nplace (State or Foreign pryland
	yland at		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Ba-f sl	Director	Maryland Montgomery Silver Spring				1 □ Yes 2X No
	23a or 2 ust be no		10e. Street and Number 10f. Zip Code 20905		_	Citizen of What Co	untry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Predical Examinar must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Sive Year or Dates: 13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P 1 □ Yes 2 ☒ No Specify:	? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Ame Black, White Specify: Wh:	, etc.
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e, Z	1 and Health em 27 ther tr	-	Irene Frances Bakersmith/Sister 15007 Peach Orchard 20a. Method of Disposition 20b. Place of Disposition (Name of	Road, S		r Spring,	
Baltimore,	t. Pages tment of tant: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory or other place) Metropolitan Crematory	Jan. 19, 2009	Ale	exandria	, Virginia
Bal	permi Depar Impor any Ir		21. Signature of Funeral Service Licensee 22. Name and Address of Facility. Francis J. Colli. 500 University B	ns Funer	al Ho	ome Inc. lver Spr	ing,MD 20901
	Physician /Medical Examiner	or.	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Diff (or as a consequence of): Sequentially list conditions, if any, leading to immediate	1	y arrest,	ase	Approximate Interval Between Onset and Death
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Division of Vital Records, P.O. Box 68760, Control

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		For		St	ate of M	aryland			Health and N	lental Hy	giene		
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pu »		Usual Residence of				10a City	Town or Lo	antian					10d. Inside City Limits
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and fealth m 27 her tr		Edwin Ar		alina	o/Nephe	_			Park Cour				
Pages 1 nent of H int: If iter iry or oth		20a. Method of Disp 1☐ Burial 2 [3 ☐ Remo	val from State	20b. Pla	nce of Dispo	sition <i>(Nam</i> e of natory or other plac tan Crema	ce) Jan	Date 21,	20c. Loca	tion - City or T	own, State
		4 ☐ Donation 21. Signature of Fu				metr				009	Alexa	andria,	Virginia
permit. Departr Importa any Inju		21. Signature of Fu	An M	AVYIVI	lla				Se Collin				
	\dashv	23a. Part 1. Enter th	he disease, or	complicatio	ns that cause	d the death.			rsicy blvong, such as cardiac			er Spri	ng, MD 20901 Approximate
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	Medical	29a. Certifier (Check only one)		Examiner:		of examinati			me, date and place, opinion, death occur				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Jan. 16, 2009 Carlos Villafuerte 1530 Jose Agustin 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months 1 XM 2 □ F Hours none 10,1982 Guatemala May Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Rockville MD Montgomery 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1108 Scott Avenue 20851 Guatemala 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. 1 Never Married 2 ☐ Married ^{2□No} Specify: Guatemalan 1 Yes White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unemployed none 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Candido Villafuerte Segastume Maria Adela Agustin Palma 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Byron Villafuerte/Cousin 1108 Scott Avenue Rockville, Md. 20851 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Remayal from State Cemeterio General: 1/27/2009 Ipala, Guatemala 4 Donation /5 ☐ Other (Specify) 21. Signature neral Service Lic PHYTIPADESRINALDI FUNERAL SERVICE, P. A 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiac arrest Due to (or as a consequence of): Pneumocystis carini pneumonia Sequentially list conditions, Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last End stage AIDS Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending

requires that the death certificate be executed and burial-trar attending physician for use as the buria Box 68760 signed by the a P.O. Division of Vital Records, has page 2 s certificate Physician: director,

this funeral

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To the Hospital or Attending P.
within 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral

Physician

/Medical

Examiner

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28a-f show

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permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other trailmain.

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Certification:

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2 Accident 3 Suicide

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29b. Signature

Maryland 21215-0036

Baltimore,

Director

Funeral

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r than "natural", or items 23a or 28a-f sho the Medical Evaminer roust be notified at

Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Jan.17,2009

🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 29d. Date signed (Month, Day, Year)

on who completed cause of death (Item 23a) (Type, Print) address of pe Sirak H.Lemma MD

1500 Forest Glen Road Silver Spring, Md 20910

D0065069

State Registrar

JAN 21

31. Date filed (Month, Day, Year)

investigation

6 Could not be determined



3

MD

State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 Year Month Physician 4:20 Pm 12, Jan. Russell Charles Allen /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Sinai Hospital Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs.] 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 218-48-6813 March 8,1948Maryland Director 60 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, It is Medical Examination and Injury or other traumatic event, It is Medical Examination. 1 X Yes 2 ☐ No Director Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21216 USA 2302 Lyndhurst Avenue Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Black þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) State Government Employment Specialist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Francis Garfield Allen Eleanor Gibson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 205 E. Joppa Rd Unit 2701 Towson, MD 21286 Russell Lynell Allen Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Richard's Mem Park1/17/2009 Easton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Henry Funeral Home, PA 21. Signature of Funeral Service Licensee 510 Washington St Cambridge, MD 21613 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Heart disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner MOID Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed burial-transi CRONCKI and Box 68760. physician Physician/Medical the attending pt IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. ed by the a 9 Unknown 9 Unknown signed by t t be detach but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 5 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No cate has been signal page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 ☑ No certificate 1 ☐Yes 2 ☐ No or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral D Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300 Garnson BWJ HOUSY MD 32. Registrar's Signature Year) 31. Date filed (Month, Day,

State Registrar

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36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, in it witch Examinar must be notified at once.	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 □ Yes 2 □ N If Yes, Give Year or Dates: 1	io anaitt	i	Yes 2. TXN			nican, etc.)		Black, Whit Specify:Cau	,
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Division of Vital Records,	afor A after Direct	Certification:	4 ☐ Homicide determined	28e. Place of Inju building, etc	(Specify)	o, lam, sire	oci, lactory, onic	,0		City or To			arai Floute Number,
	To the Hospital or Attending Physician; within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, to the funeral director.	Medical C	29a. Certifier 1 Certifying F (Check only one)	Physician: To the best of aminer: On the basis of and manner sta	f examinatio	edge, death on and/or inv	n occurred at th vestigation, in n	e time, date ny opinion,	and place death occur	, and due to the rred at the time	e cause(s , date an	s) and manner a d place, and du	is stated. e to the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier	0 -1	1		29c. Lic	ense numbe	er		29d. Da	ate signed (Mon	th, Day, Year)
	6 1 1		- January	2 11/11	Min	^	0	658	30		TA	princey	14 2009
	4+1		30. Name and addr. of person who Jamie Patricia Mo	orano, MD	99	01 Me	_{Print)} dical C	enter		e, Rock		.e, MD 2	
	[≠] Sta Registr		31. Date filed (Month, Jan Kear)	2009 ^{32. Registra}	ar's Signatur	B. 1	parked						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 7200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner skington Hospital ashington County agers 04 8. Date of Birth (Month, Day, 77. Age (In yrs. last birthday) If Under Vear | If Under Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** Min. 1 □ M 2 💢 F Months Days Hours 258-99-2542 01 akistan Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Mcdical Exercise to use the profiled at once. 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Completed by Funeral Director 1 XYes 2 No Wash Hagers lowr 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pakistan 20004 21742 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: 3 X Widowed 4 ☐ Divorced Asian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home maker OUn 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Babylon ct. Hagers Town MD 21742 KHALID (SON) 20004 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Sahiwal akiwal 01/23/09 4 Donation 5 Dother (Specify) Muslim Funeral Se 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 1242 EASY 5%. UA-22191 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MyoCardya ulle disease or condition resulting in death) /Medical Due to (or as a consequence f): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or): Physician/Medical Examiner within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D2145 2009

State Registrar DHMH 17 Rev 1/2001 DAKHIL

Wiz.

12821-

HAGIERSTEWN MD 21742

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

gegistrar's Signature

Lucia

AHEED

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Month Day 2009 Year Physician Busby Bartos January 18, 6:50 pM Catherine /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery Holy Cross Hospital 8. Date of Birth (Month, Day, Yeer If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday Birthplace (State or Foreign
Country) **Funeral** Months Days Hours Min. 1 ☐ M 2 🔀 F Dec. 10, 1933 Alabama 75 419-36-9715 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 structures.

Department of Health and Mental Hygiene.
Important: If them 27 is marked other than "natural", or items 23a or zoor. surprise in your properties of the motified at any injury or other traumatic event, the Motified Examination to use the motified at once.

The Completed by Funeral Director 1 ☐Yes 2 V No Silver Spring Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20905 USA 1804 Cullen Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. □Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No If Yes, Give Specify: White 3[™] Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Legal 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Louise Goff Charles Busby 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paula C. Compton/Daughter 2 William Court, Emmitsburg, MD 21727 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Metropolitan Crematory 19, Jan. 4 ☐ Donation 5 ☐ Other (Specify) 2009 Alexandria, Virginia 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee 500 University Blvd, W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Bilateral Pneumonia **Physician** 2 Days /Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underl, in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-tran and Due to (or as a consequence of): O. Box 68760 physician Physician/Medical attending p IF FEMALE: nse If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Year 5 ☐ Other (specify) been signed by the should be detached ☐Yes 2 🗷 No 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by Chronic Obstructive Pulmonary Disease, Acidosis, Sepsis, Malnutrition 1 X Yes 2 No 3 Probably 4 Unknown has been 24b. Were autopsy findings availeble prior to completion of cause of death? Failure To Thrive, Multiorgan Dysfunction 24a. Was an page 2 autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ▼ No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2⊠No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 24 hours after death.
Funeral Director; After the etely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 hor To the Fune completely fi 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number January 19, 2009 D53367 30. Name and address of person who completed cause of death (Item 23a) (Type, Print).

Rajan Styramsundar, MD 9801 Georgia Avenue, #117, Silver Spring, MD 20902 Rajan Shyamsundar, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 parke Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** MARGARET BROWN P^{M} J. 17,2009 1:00 January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 9 Chesnut Street Gaithersburg Montgomery 8. Date of Birth (Month, Day, Ye Feb. 12, If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Year) Washington D.C. **Funeral** 1 □ M 2 🗓 F 87 577-12-7726 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Evancians of mailing at 1 X Yes 2 No Director MD Montgomery Gaithersburg 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 9 Chesnut Street #113 20877 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry Lickner Hester L. Russell ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar. Important: If item 27 Is I any injury or other traui Margaret V. Fisher (Daughter) 9 Chesnut Street #218 Gaithersburg, MD 20877 Date 19 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Jan. 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Metropolitan Crem. 2009 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final INFARCTION Physician MYOCARDIAL disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if the line to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed and Due to (or as a consequence of) physician ar s the burial-ti O. Box 68760 Physician/Medical as t attending p IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 \(\subseteq \text{ Ectopic pregnancy} \) in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) signed by the a 9 Unknown 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown been signature should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has t autopsy performed? Yes 2-2 No certificate I 1 □Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 \$\mathbb{M}\$ Residence 6 Other (Specify) 1**∑**Yes 2 🗆 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. 28d. Describe how injury occurred Injury at Work? 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of eartifier

Registrar

State

20528 Boland Farm Road

#104 Germantown, MD 20876

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

37 Registrar's Signature

Dr. Barry R. Nahin M.D.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar AMEND#10bperFH1/26/09, BWW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day 18 2009 Borkowitz Mollie January /Medical 4a. Facility Name (If not institution, give street and number) County of Death 4b. City, Town, or Location of Death Examiner Ellicott City Howard 5330 Dorsey Hall Drive #206 If Under 24 Hrs. 8. Date of Birth Nownth 3ay, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 □ F Months 94 064-12-8376 Director New York Usual Residence of Decedent 10b. County Howard 10c. City, Town or Location show 10a. State 10d Inside City Limits d 2 should be filed within 72 hours after death with the Marylar th and Mental Hygiene. It and Mental Hygiene. ? Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Ellicott City Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21042 United States 5330 Dorsey Hall Drive #206 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Education Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jennie Levine Charles Greenberg Pages 1 and 2 should here ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5362 Five Fingers Way, Columbia, MD 210/15 Department of Health ar Important: If Item 27 Is any Injury or other trau once. Janet Grimes, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 □ Removal from State King David Memorial Garden 01/21/09 Falls Church, VA 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Pervice Torchinsky shebrew Funeral Home 254 Carroll St., NW, Washington, DC 23a. Part1. Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on gach line. Immediate Cause (Final disease or condition resulting in death) (grdiovas cular Disease **Physician** /Medical Dementia Examiner dvance Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, 🚗 The law requires that the death certificate be executed and Due to (or as a consequence of) physician the IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performe 2 No or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Softher (Specify) ASSIS GILLIN 2 ER/Outpatient 3 DOA Certification: To After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D36641 01/19/09 17 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Back River Necle Road Baltimore Maylad Kamech 32 Registrar's Signatur 31. Date filed (Month, Day, Year) State

Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 10 DWK /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Montgomery Takoma Park Washington Adventist Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1X M 2□ F Director 70 Maryland 217-34-2324 April 21, 1938 Usual Residence of Decedent 10b. County 10c. City, Town or Location th and Mental Hygiene. 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, It's Medical Examiner must be notified at 10a. State 10d. Inside City Limits Director 1 ☐ Yes 2 No MD Calvert Sunderland the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with USA Funeral 7620 Wayside Drive 20689 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ∏Yes 2X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. þ Specify 3 Widowed 4 □ Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cement Finisher Construction 12 18. Mother's Name (First, Middle, Maiden Surname) Be (17. Father's Name (First, Middle, Last) မ Warren Brown **Emma Ethel Chase** 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any Injury or other trau once. 7620 Wayside Drive, Sunderland, MD 20689 Gregory L. Brown - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State tX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Patuxent UMC Cemetery 1/24/2009 Huntingtown, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Hade Sewell Funeral Home, P.A., 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a cons quence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely littled in by the funeral director, page 2 should be detached for use as the burlar-transit completely littled in by the funeral director, page 2 should be detached for use as the burlar-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown Part IL Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 3 Probably 4 ☐ Unknown Be Completed 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 11Vo 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 (No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification; To Date of Injury (Month, Day, Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide I [Livertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

Lacutchina

of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		For State Registrar	State of M	aryland /	Departm		ealth and l		jiene	0.00	0006
Physic		Registrar1. Decedent's Name (First, Middal)John	le, Last) McKinl	еу	Burle		<i>Jean</i>	2. Date of Deal Month	eg. No. 2 th Day	2009 2009	3. Time of Death
/Medi Exami		4a. Facility Name (If not institutio	n, give street and number,			City, Town, or	Location of Death	<u> </u>	4c. Co	ounty of Death	1
Funeral Director		5. Social Security Number 214–34–2057	6. Sex 7. Ag	ge (In yrs. last I 81		nder 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 10/03/	Year)	9. Birth	place <i>(State or Foreign</i> ntry) nsylvania
aryland show	Ž	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Location				-	1	10d. Inside City Limits 1
ith with the Maryland 23a or 28a-f show ust be notified at	Il Director	MD A. 10e. Street and Number 1528 Oldto	llegany wn Road			erland i. Zip Code 2	21502	1	0g. Citize	n of What Cour	Λ
2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show raumatic event, I'm Mydical Evan in a tout be notified at	by Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Mar	If Yes, Give	[?] № 1950 -	_	ecedent of Hispecify Cubar	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		. Race - Americ Black, White,	etc.
in 72 hours n "natural" Avdical Ex	Completed b		nt's Education est grade completed)		Ga. Decedent's (Give kind of life. DO NO	Usual Occupa if work done d OT use retired,	ition uring most of wor	king		of Business/In	nite _{dustry}
e filed with al Hygiene. other than vent, the	Be Com	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle,	College (1-4or 5	5+)	Те	acher	18. Mother's Nan	ne (First, Middle, I		olic Sch	hools
2 should be and Menta is marked aumatic e	To	Charles 19a. Informant's Name/Relations				,		ıral Route Numbe			o Code)
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once.		Robert C. Adam 20a. Method of Disposition 1 Burial 2 X Cremation		20b. Place ceme	of Disposition itery, crematory	(Name of or other place	9)		20c. Loca	tion - City or To	
permit. Pa Departmer Important any injury once.		4 □ Donation 5 □ Other (5		Cumber	22. Nan	ne and Addres			ly Fu		, MD Home, P.A. 21502
Physician /Medical Examiner		23a. Part . Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	aa. Due to (or as	d the death. Dine. P	not enter the	mode of dying					Approximate Interval Between Onset and Death
cate be executed bhysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	S c	s a consequenc	,						
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the buri	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e of pregnancy 2 Fetal dea at time of death		pic pregnancy er (specify)			23	d. Date of deliv Month	ery Day Year
quires that en signed b uld be deta	5	Part II. Other significant conditi	ions contributing to death	but not resulting	g in the underly	ing cause give	n in Part I.			contribute to t	he cause of death? bably 4/1 Unknown
The law re ate has be page 2 sho	Completed							24a. Was a autops perfore	med?	24b. Were auto prior to co death? 1 □Yes	opsy findings available ompletion of cause of
ysician: is certific director,	Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ient 2□ER/	Outpatient 3	DOA Othe		ith <i>(Check only on</i> Iome 5 ☐ Resid		☐Other (Speci	fy)
tending Ph leath. tor: After th the funeral	Certification: To	27. Manner of Death 1 Natural 5 Pendii 2 Accident invest 3 Suicide 6 Could	igation	ay, Year)	D. Time of Injury		at	28d. Describe ho	ow injury o	occurred	
pltal or At ours after c eral Direct filled in by	I Certifi	4 ☐ Homicide deterr					ne, date and place	City or Town	n, State)		al Route Number,
the Hos hin 24 ho the Fun	Medical	(Check only 2 Medical one)	Examiner: On the basis and manner s	of examination	and/or investig	ation, in my o	pinion, death occu	irred at the time, o	late and p	lace, and due t	o the cause(s)
P P P P	2	29b. Signature and title of certific	/ u/	?		29c. License				signed (Month,	d, MD 26
nes		30. Name and address of person	aditya	death (Item 23: trar's Signature	ai 9	ay Se	ton DR	ive, C	uml	perlan	d, mo ar

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5:15 A

10d. Inside City Limits

Day

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Year

1 □Yes 2X No

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

29b. Signature and title of contifier 29c. License number 29d. Date signed (Month, Day, Year) MD D67788 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hisso Rol. Charlatte Haso, Md. 30622 KODALI-3944 Charlette
32. Rigistrar's Signature LEENA RAO 31. Date filed (Month, Day, Year) State

Registrar

3 ☐ Suicide

29a. Certifier

Medical

4 ☐ Homicide

(Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 2009 ETHEL LEE BROOKHART unknown Jan. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) | Joppa | | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 12/7/1940 | Examiner 322 Sweet Briar Court Harford Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1□ M 🏖 F 68 192-30-2110 Pennsylvania Director Usual Residence of Decedent 10d, Inside City Limits death with the Maryland 10c. City. Town or Location 10a. State iral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Harford Director MD. Joppa 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21085 United States 322 Sweet Briar Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Iem 27 is marked other than "natural", or iter 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 📉 No Specify: Baltimore, Maryland 21215-0036 Specify: þ White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Sales Manager Department Store 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary William Malone ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and Department of Health Important: If Item 27 i any Injury or other tra once. Ruth Malone (Sister-in-law 6300 Catherine St. Harrisburg, PA 17112

20a. Method of Disposition

20b. Place of Disposition (Name of cemetery, crematory or other place)

20c. Location - City or Town, State 20a. Method of Disposition ¶ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Jarrettsville Cem. 1/30/09 Jarrettsville, MD. 21. Signature of Funeral Service Lio see 22. Name and Address of Facility E.G. Kurtz & Son Funeral Home, Jarrettsville, Maryland P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lice. Immediate Cause (Final disease or condition resulting in death) INFARCTION MINUTES Physician MYDCARd /Medical Due to (or as a comequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner death certificate be executed burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the as 1 IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) ed by the a detached 1 9 Unknown 9 Unknown sate has been signed I page 2 should be dete Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 25 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2 No certificate Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ို 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? Certification: After the Hospital or Attending (Month, Day Year) 5 ☐ Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hours after the Funeral Dire [Effectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 7362 A. n. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) York Rd 326 Lumerville And 21093 Serthis mo 1205 Mon 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 0 4 2009 Registrar

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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 9:44 p M 1Ó 2009 Frederick Clair Crotzer January /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Silver Spring Montgomery 13601 Creekside Drive Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1 ☑ M 2 ☐ F Yrs. December 9, 1935 Pennsylvania Director 579-48-1153 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show Sa or 28a-f show 1 ☐ Yes 2 K No Director Silver Spring Montgomery Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, I'm Medical Examinations and once. U.S.A. 13601 Creekside Drive 20904 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ☐ Never Married 2 Married 1⊠Yes 2∐No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates:1952-1954 1 ☐ Yes 2 🛣 No Specify: Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Vending Mechanic 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clair Booth Crotzer Gertrude Eliza Kopp ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13601 Creekside Drive, Silver Spring, Maryland 20904 Judith A. Crotzer - Wife 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory 01/21/2009 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Chronic Obstructive Lung Disease /Medical Due to (or as a consequence of): Examiner Aortic Stenosis Sequentially list conditions, if any, leading to inneclate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and stely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 🗍 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>چ</u> 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🖾 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 ☐ Yes 2 🛛 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Injury 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 24 hours a 1⊠ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

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State

Registrar

ORIGINAL

Dark

Riva Gill, M.D., 6510 Kenilworth Avenue, Suite 2400, Riverdale, Maryland 20737

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month Day, Year) AN 20

D0050951

January 12, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year 2009 3:40A January 16, Cohen 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Bethesda Montgomery Suburban Hospital If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Social Security Number Days 1 □ M 2 🕅 F Ohio May 3, 1922 065-12-5579 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County 1 XYes 2 No Montgomery Rockville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6121 Montrose Road 20852 United States 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ∐Yes 2**X** No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 □XNo Specify: White 3 ☑ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ty vil Service Elementary/Secondary (0-12) Δ^{College (1-4or 5+)} Clerical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rose Nemeth Albert Jacobs 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Regina Cohen - Daughter 1800 Old Meadow Road Apt 604 McLean VA 22102 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1/18/2009 Beth David Cemetery Elmont, NY 22. Name and Address of Facility 21. Signature of Fureral Service Licenses Danzansky-Goldberg Memorial Chapels Inc 1170 Rockville Pike Rockville MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): d. Date of delivery Month e contribute to the cause of death? 4 Unknown 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

Physician /Medical Examiner

Physician

/Medical

MD

Director

Funeral

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "hourd Examination in the rediffical and injury or other traumatic event, the "hourd Examination in the profiled at

the Maryland

filed within 72 hours after death with

Baltimore, Maryland 21215-0036

P.O. Box 68760

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ospital or Attending Physician: hours after death. within 24 hours after death

To the Funeral Director:
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Sequentially list conditions, if any, leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): c. Due to (or as a consequence of):	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)	23d. Date of delivery Month Day Year
Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death
		24a. Was an autopsy findings ava prior to completion of caus death? 1 □ Yes 2 □ No 1 □ Yes 2 □ No
25. Was case referred to medical	26. Place of Death	(Check only one)
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Hom	e 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work?	3d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		3f. Location (Street and Number or Rural Route Number City or Town, State)
29a. Certifier 1 ertifying Pl	nysician: To the best of my knowledge, death occurred at the time, date and place, a niner: On the basis of examination and/or investigation, in my opinion, death occurre	nd due to the cause(s) and manner as stated. d at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier Crowd No 29c. License number D66896 29d. Date signed (Month, Day, Year) 09

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Matthew Madison Leonard MD 8600 Old Georgetown Road Bethesda MD 20814

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 2009 1625 Arthur Steven Cohen January 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital Olney Montgomery If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) USTUCT 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year, Months Days Hours Min. 10XM 2□ F 579-40-0849 July 10, 1933 of Columbia 75 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b. County 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö "natural", or Items 23a 20906 Funeral 2709 Hewitt Avenue u.s.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Ye ar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No \$ 3 Widowed 4 Divorced Specify White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any Injury or other traumatic event, Ita Ma Elementary/Secondary (0-12) College (1-4or 5+) Pharmacist Giant Foods 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ralph Cohen Florence Malmed 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Muriel Cohen - Wife 2709 Hewitt Ave., Silver Spring, MD 20b. Place of Disposition (Name of cemeters crematery or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/19/2009 | Falls Church, VA Memorial Gardens 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Dicensee Nance 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart billure. List only one cause on each line. Immediate use (Final disease or condition resulting in death) entra **Physician** minute s /Medical Due to (or as a consequence of) Examiner Corona Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transi be executed and Due to (or as a consequence of) Box 68760. the attending physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy for in the past 12 months? Month Year 5 Other (specify) 1 Tyes 2 No Ö 9 Unknown ģ σ. s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. ð 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 s autopsy performed Yes 2 No 2 🗹 No of Vital 1 ☐ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To After thi funeral 28a. Date of Injury (Month, Day, Year) 27. Magner of Death 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

State Registrar

12

Prince P

h.l. o Drive Olney, Mayland 20832

who completed cause of death (Item 23a) (Type, Print)

18109

32. Pegistrar's Signature

Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 18 Month Year COWAN JAMES 2009 1300 01 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Fore Country) 9. Pennsylvania Birthplace (State or Foreign Country) 1**X** M 2□ F 78 167-22-0867 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Maryland | Montgomery Rockville 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? 8 Baltimore Road 20850 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 XYes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2X No Specify. Specify: 3 Widowed 4 Divorced Korea White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) College Administrator Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Herbert Cowan Bernice Denny 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julia G. Smith/Daughter 9011 Hempstead Avenue, Bethesda, Maryland 20817 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Jan. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 Metropolitan Crematory Alexandria, Virginia 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licenses 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pneumonia 2 weeks Due to (or as a consequence of): Years Dementia Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

Physician /Medical Examiner

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Division of Vital Records,

Hospital or Attending Physician:

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er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

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permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is any Injury or other trau once.

1 and 2 should be Health and Mental

Baltimore, Maryland 21215-0036

/Medical

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Block

24a. Was an 2 No 1 ☐ Yes

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 ☐ Yes

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

1 Natural

2 Accident

4 Homicide

3 ☐ Suicide

5 Pending investigation 6 ☐ Could not be 28a. Date of Injury (Month, Day, Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Mittalni

1 inpatient 2 ER/Outpatient 3 DOA

28b. Time of Injury 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated.

29b. Signature and title of certifier

D0061382

29d. Date signed (Month, Day, Year) 01-19-2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

14816 Physicians Lane, Suite 152, Rockville, MD. 20850 Shama R. Mittal, M.D.,

State Registrar

32 Registrar's Signatu 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 10:25 PM Coccaro Gargiulo /Medical 7, 2009 4c. County of Death 2009 January 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carriage Hill Nursing Home Montgomery Bethesda If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🔀 F 133-05-0223 95 Director 08/21/1913 New York Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County iral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo Maryland Montgomery Chevy Chase 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5600 Wisconsin Avenue #802 20815 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 2 No 1 ☐ Never Married 2 ☐ Married 1 ∐Yes 2X No Specify. Specify: White 2 3 ☑ Widowed 4 ☐ Divorced "natural" Completed event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than amy injury or other traumatic event, In Manee. Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Gargiulo Laura Desimone ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Peter J. Coccaro Jr. / Son 8611 Village Park Place Chevy Chase, MD 20815 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Gate Of Heaven Cem Feb 14,2009 Hawthorne, NY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral San 5130 Wisconsin Ave. NW Washington, DC 20016 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ust only one cause on each line. 23a. Part 1. Enter the disease shock, or heart failure. I Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Congestive Heart Failure /Medical Due to (or as a consequence of) Examiner Hypertensive Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine Chronic Obstructive Pulmonary Disease sician and burial-trans Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 💆 No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Atrial Fibrillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2X No 1 ☐Yes 2 ☐ No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, attending physician for use as the buria been signed by the should be detached s certificate has t lirector, page 2 s this after death.

Director: /

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

n 24 hou. the Funeral Dire completely To the within 2 To the

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated.

29b. Signature and title of certifier

29c. License number

D35579

29d. Date signed (Month, Day, Year) January 8, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Susan Miller MD 6844 Tulip Hill Terrace Bethesda, MD 20816

State Registrar

Medical

31. Date filed (Month, Day, Year) JAN 21



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 2009 January 14, /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Bartholomew House Bethesda Montgomery Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 5 Social Security Number 6. Sex **Funeral** Year) Months Days Hours 1 □ M 2 🖾 F 171-07-6313 22 PA Director 100 Nov. Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 28a-f show d 2 should be filed within 72 hours after death with the Maryla th and Mental Hygiene. 22 hours 23a or 28a-f shov trammerted other than "natural", or items 23a or 28a-f shov trammatic event, the Medical Extra inversinant be a cliffed at TX Yes 2 □ No Director Bethesda Montgomery Md 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20817 Funeral 6904 Riva Rd 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a: Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Federal Government Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Leo C. Cassidy Elizabeth Delozier ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 1688 East Gude DR # 102 Rockville, Md 20850 Anthony Saradakis / Attorney 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jan. 17,09 Altoona, PA Calvary Cemetery 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral Service Licensee 5130 Wisconsin Ave. NW Washington, DC 20016 Will-a 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Diabetes disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Coronary Vascular Disease Atherosclerotic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of certificate be executed Exami sician and burial-trans Due to (or as a consequence of) P.O. Box 68760, ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) □Yes 21 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 □ No 1 □Yes 2 □No 1 Tyes Hospital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Semi aroll Hospital: Other: 4 Nursing Home 5 Residence 6 Dother (Specify) Living 1∐Yes 2∑No ပ္ 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day, Year) 28h Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After 1 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No nours after death.

neral Director: / 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated the the the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie o ¥ o DO 30247 2009 01/14 Allan Morrison, M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

DHMH 17 Rev 1/2001

Registrar

103 Washington D.C 20016

#

32 Registrar's Signature

NW

5410 Connecticut Ave

31. Date filed (Month, Day, Year)

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			For	State of Ma	aryland					ental Hy	giene			~ ~ .
			1 - State Registrar			Ce	rtificate	of Death			Reg. No	<u> 200</u>	9 030)/(
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Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death										10	4c.	County of De	C C C L	
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	yram.		10a. State 10b. County		10c. City, Town or Location							10d. Inside City I		
	8a-f s	Director	Maryland Alleg	Frostburg							1 Yes 2	No		
	23a or 2 ust be n		10e. Street and Number 41 Sto		10f. Zip Code 21532-					10g. Citizen of What Country? U.S.A.				
0500-61	items items ner mu	Funeral	11. Marital Status 1 □ Never Married 2 □ Married	Ever in U.S.	13.	Was Decedent If Yes, specify	Decedent of Hispanic Origin? (Specify Yes or N s, specify Cuban, Mexican, Puerto Rican, etc.)			-	14. Race - Ar Black, Wi	nerican Indian, nite, etc.		
	urs an al", or Exami	þ	3 Widowed 4 □ Divorced	1 ☐ Yes 2 📉 I If Yes, Give Year or Dates:	If Yes, Give		1 ☐ Yes 2 🔀 No Specify:					Specify: White		
	/z no 'natur dical I	eted	15. Decedent's I (Specify only highest g	16a. Decedent's Usual Occupation (Give kind of work done during most of wo			at of working	,	16b. K	ind of Busines	ss/Industry			
7	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Healith and Mential Hyglene. Inmoortant: If them 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	Elementary/Secondary (0-12)	Elementary/Secondary (0-12) 4 College (1-4or 5			+) Chief Engineer				State College			
andz		To Be Co	17. Father's Name (First, Middle, Last) Albert W. Capel 18. Mother's Name Beatrice A							(First, Middle, Maiden Surname) A. Wright				
Mary			19a. Informant's Name/Relationship (Type. Print) Kathy Diehl granddaughter				19b. Mailing Address (Street and Number or Run 11607 Pond Cove Road Mi			Route Number, City or Town, State, Zip Code) othian Maryland 21543-			-	
ore,			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	☐Removal from State			osition (Name of matory or other		Da			100	or Town, State	
altimor			4 □ Donation 5 □ Other (Specify) Rest Lawn Memorial Garden							ry 21, 2009	LaV	ale	Maryland	
Da Da			21. Signature of Funeral Service Lice	ensee		2	2. Name and A Durst F	uneral Hor	-	rost Ave	e., Fro	stburg, M	ID 21532	
			23a. Part1. Enter the disease, or con shock, or heart failure. List onl	mplications that caused y one cause on each li	the death. I	Do not en	ter the mode of	dying, such as	cardiac or	respiratory a	rrest,		Approximate Interval Betwe	eņ
	hysician and attenuing physician and to as the parial-transit to as the		Immediate Cause (Final disease or condition	a End	End stage Dementia								Onset and Dea	ath 25
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5	the at	Physician/Medic	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 □ Pregnant at time of death 5 □ Other (specify)								Month Day Yea		al .
7	ned by detac	y Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause of death?				
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_ F	To the Hospital or Attending Physician: The law requires that the dividing the Law	Con								t Perfo	ormed? 2 No	death 1 ☐ Y		
VITA		Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Other: 4 Other (Specify)										
ō		: To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury 28b. Time of 28c. Injury						28d. Describe how injury occurred				
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DIVISION		Certification:	3 Suicide 6 Could not 4 Homicide determine						28	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
		Medical (
i	vithin To th compl	Me	29b. Signature and title of certifier		29c. License number				29d. Date signed (Month, Day, Year)					
}	3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WONSOCK SHIN 925 BISHOP WALSH RO C 31. Date filed (MANAPA) par 2009 22. Registrar's Signature						25	Jan 18, 2009				
	1128		30. Name and address of person wh	completed cause of d	BISH	Ba) (Type,	Print)	RO C	umbe	sland	1	YD 21	507	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** hanie)anuary 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 140 Sptal at Easton
6. Sex 7. Age Illn vis last hirthe labot Memorial Fustor
If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 2 18 - 40 - 5630 7. Age (In yrs. last birthday)
6 5 Yrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Months Days Hours Min. June 6,1943 Maryland Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 Is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Ever. i mr. rust tw. nutlind at 1 1 Yes 2 □ No Director Dorchester ambridge 10e. Street and Number 10g. Citizen of What Country? 2/6/3 Washington USA Completed by Funeral death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married 5-0036 1 ☐ Yes 2 🗷 No Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 2121 Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Operator 0 hine *−00d* Itimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cephas William Hooper Jenkins ၉ f Health and N tem 27 Is man 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Cambridge, 820 Washington Cephas Georgia other ! permit. Pages 1 and Department of Heali Important: If Item 2 any Injury or other otice. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Shore Crenation 109 Cambridge 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
HENRY FUNERAL Home, P.A.
510 washington St. Cambridge 21. Signature of Funeral Service Licensee 23a. Patr. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Vascular erepro **Physician** 2 day /Medical Examiner Sequentially list conditions, if any, leading to minimal decause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Examine Physician: The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA After this Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 5 Pending 1 ☐Yes 2 ☐ No investigation 24 hours after death. Funeral Director: / 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. (Check only one) within 2 To the 29c. License number 0053815 29b. Signature and title of vertified 29d. Date signed (Flonth, Day, Year) 1/21/2009

Registrar
DHMH 17 Rev 1/2001

State

912 DMarke

32. Registrar's Signature

St Denton MD 2/629

Name and address operson who completed cause of death (Item 23a) (Type, Print)

KORAH PULIMOOD

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 11:20 P 1/20/2009 Ruth James Creighton /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 114 Oakley St. Dorchester Cambridge If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2 🔀 F 3/5/1921 Director Maryland 214-12-6458 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinat must be notified at 1 XYes 2 □ No Director Dorchester Cambridge Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 114 Oakley St. 21613 LISA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 ₩ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Owner/Manager Real Estate 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Blanche Dean ပ George Willey Hall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Edward James / Son 1240 Pennsylvania Ave., Madison, MD 21648 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 1/23/2009 Cambridge, MD 4 ☐ Donation 5 ☐ Other (Specify) Dorchester Memorial Park 21. Si an of Funeral Service Licensee 22. Name and Address of Facility CONCEREC Curran-Bromwell Funeral Home, P.A., 308 High St., Cambridge, MD 21613 Merrica Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ocido sis Physician disease or condition resulting in death) /Medical Due to (or as a conseque te of) Examiner ypertensive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed anding physician and use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month 5 Other (specify) cate has been signed by the page 2 should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed 2 **4**N6 1 ☐Yes 2 ☐No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aresidence 6 Other (Specify) 1 Yes 2 INo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To nours after death.

neral Director: After this

filled in by the funeral di 28a. Date of Injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 □ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

within 2 To the

29b. Signature and title of certifier

NOMAN 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THANWY

DHMH 17 Rev 1/2001

State Registrar

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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

CAMPRIDGE MD 216/2

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 03073 Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** 2009 Mary Kovakas Condeelis January 10:10 A^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6508 Western Avenue Chevy Chase Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 X F Yrs New York Director 1936 231-44-3356 Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10a. State 10h Counts 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Invoical Examiner must be notified at 1 ☐ Yes 2X No Funeral Director MD Chevy Chase Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6508 Western Avenue 20815 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ②☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Executive Director <u>Non-profit</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce. h and Menta Nicholas Kovakas Diane Johnson 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 600 W. Taylor Run Pkwy. Alexandria, VA 22314 Chris Condeelis/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) W. Arundel Crematory 01/22/09 Odenton, Maryland 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784
Beverly L. Heckrotte, P.A. Clarksville, MD 21029
Approximate 21. Signature of Funeral Service Lice. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final **Physician** disease or condition resulting in death) Non Small Cell Lung Cancer 15 months /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) requires that the death certificate be executed that initiated events the burial-tra resulting in death) Last Due to (or as a consequence of): physician Division of Vital Records, P.O. Box 68760, Physician/Medical use as attending IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy for in the past 12 mont Month Day Year 5 Other (specify) detached 9 Unknown 9 Unknown à s been signed b should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1

Yes 2

No 3

Probably 4

Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has N autopsy page, performe 1 ☐ Yes 2 No Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 XNo Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 XNatura! 5 Pending To the Hospital or Augustin 24 hours after death.

To the Funeral Director: Aft investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide 29a, Certifier 1 Ccrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) (DC) 09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James D. Ahlgren, M.D. 2150 Pennsylvania Ave. NW Suite 3-428 Washington, D.C. 20037 31. Date filed (Month Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2009 Amended 1- State Registrar #5, FH, TCHD, 01/21/09 pha Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician UMMINGS HARRY 09:01 PM 2009 10 /Medical Danvary 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year)

JUN 15, 1935 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** 1 XM 2 🗆 F Months Days 215-36-2041 Director 73 **MARYLAND** Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 X Yes 2 □ No TALBOT TILGHMAN MD 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 21396 SINCLAIR ROAD 21671 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian Black, White, etc. filed within 72 hours after 1 Yes No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ★ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: \$ Specify: WHITE 3 - Widowed 4 - Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 6 WATERMAN SEAFOOD other Ith and Mental Hygie 27 Is marked other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ANDREW CUMMINGS ANNA M. RIMMER ဂ္ Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 21396 SINCLAIR ROAD, TILGHMAN, MD 21671 EVELYN L. CUMMINGS/WIFE it of Hea 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Injury or 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or once, 4 ☐ Donation 5 ☐ Other (Specify) TILGHMAN WESLEYAN CEM 1/19/2009 TILGHMAN, MARYLAND 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 10saph Jul Ostrowstr 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause an each line Interval Between immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Ves+ SDITATO 5minute /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine certificate be executed burial-trar Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No Yes 1 Tes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Hospital: Other: 4 \(\sum \) Nursing Home 1 ☐ Yes 2 No 1 Inpatient မ 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) this 27. Manner of Death 1 Natural 2 Accident al or Attending Ph s after death. Il Director: After th 28a. Date of Injury 28b. Time of 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred 5 Pending investigation (Month, Day Year) 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Hospital of 24 hours a Funeral D 29a. Certifier (check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 29b. Signature and title of ce 29c. License number 29d. Date signed (Month, Day, Year) TLS anvar who completed cause of death (Item 23a), (Type, Print 30. Name and address of person 3 600 North Wolfe St, Baltimore, MD, 21287 JAN 15 2009 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Ex	aminer	4a. Facility Name (If not institution, gi				r Location of Death		4c. County of De	
		Anne Arundel M			Annapo	lis If Under 24 Hrs.	0 Date of Birt	Anne A	rundel irthplace (State or Foreign
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yland	Ħ,	Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 Is marked other than "natural", or items 23a or 28a-f show	Director	Maryland Anne 10e. Street and Number	Arundel A	nnapol	is 10f. Zip Code			10g. Citizen of What (1 ☐ Yes 🏖 No
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death	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H	dispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No-	- 14. Race - Ar Black, Wh	nerican Indian,
036 Irs after	Saminal by Fu	1 ☐ Never Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 1 No If Yes, Give Year or Dates:		1 □Yes 2 □ No	Specify:	Tricari, etc.,	Specify: B	
Baltimore, Maryland 21215-0036 Department of Health and Mental Hyglens 17 Papartment of Health and Mental Hyglens Popratment if Hem 27 Is marked other than "natural", or	t, the Medical E	15. Decedent's E (Specify only highest gr	rade completed)	16a. Deced	dent's Usual Occup kind of work done DO NOT use retired	oation during most of work d)	king	16b. Kind of Busines	ss/Industry
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and and teath	hert	Delmar C. Chas					Date Date	1d. 21409 20c. Location - City of	or Town State
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Bal permit Depar	any ir	21. Signature of Funeral Service Lice	ensee		Name and Addre Wm Rees	, (321 Wes 3 Mortu	st St. An lary, P.A	napolis, Mo · 21401
		23a. Part 1. Enter the disease, or cor shock, or heart failure. List only	mplications that caused the de	eath. Do not ent	er the mode of dyi	ng, such as cardiac	or respiratory a	rrest,	Approximate Interval Between
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Box 68760, eath certificate be exath certificate be exattending physician	letached for use as the bu Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre- 1 ☐ Live birth 2 ☐ F	etal death 3 [⊒ Ectopic pregnand	су		23d. Date of o	delivery Day Year
P.O. F	ached for	1 □Yes 2 □No 9 □ Unknown	4 ☐ Pregnant at time 9 ☐ Unknown	of death 5L	Other (specify) _				
Records, P.O. Box 68760, he law requires that the death certificate be executed the has been signed by the attending physician and			contributing to death but not	resulting in the u	nderlying cause giv	ven in Part I.	23e. Did to		to the cause of death? Probably 45 Unknown
Division of Vital Records, I or Attending Physician: The law requires the after death. Director: After this certificate has been signe	p. ge 2 should be o	Chronic Kie	dney Disea	se, H	y pert	ension	24a. Was autop	osy prior t	autopsy findings available o completion of cause of
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Hospita 14 hours Funeral	ompletely filled		Physician: To the best of my aminer: On the basis of examand manner stated.	knowledge, deat nination and/or in	h occurred at the to	ime, date and place opinion, death occu	e, and due to the irred at the time,	cause(s) and manner date and place, and d	as stated. lue to the cause(s)
To the within 2	сотр	29b. Signature and title officertifier	Lillims		29c. Licens			29d. Date signed (Mo	
		30. Name and address of person wh	o completed cause of death (Item 23a) (Type,		006022	25	Januar	415,2009
	100								
Re	State egistrar	31. Date filed (Month, Day, Year)	2009 September 2009	gnature.	backer				
- 110	Siction	U/III-0		" "					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registrar 03076 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year BORTS CHERNOV 10:24 JANUARY 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death FREDERICK MEMORIAL HOSPITAL FREDERICK
If Under 1 Year | If Under 24 Hrs. FREDERICK 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number XX M 2□ F Months Days Hours Min. 320-96-0266 65 18, 1943 Russia Nov. Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City. Town or Location 1 □XYes 2 □ No Frederick Maryland Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4900 C Meridian Way, Apt. 27 21703 Russia 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XX No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 1 □Yes XX No Specify. Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Senior Scientist Chemistry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Konstantin Chernov Maria Kuznetsova 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julia B. Golova, wife 4900 C Meridian Way, Apt. 27, Frederick, MD 21703 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory Feb. 1, 2009 Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Keeney and Basford PA Funeral Home 21. Signator of Funeral Service Lice

Physician /Medical Examiner

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as attending I for use as

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Be 25.

Certification: To

Medical

4 Homicide

29a. Certifier

or Attending Physician; The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

10a. State

Director

Funeral

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Pages 1 and 2 should be

Health item 27 i

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permit. Pages 1 and Department of Healt Important: If Item 2: any Injury or other 1 once.

altimore, Maryland 21215-0036

th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Exonitractional by motified at

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Circust of high that initiated events resulting in death) Last Examine

disease or condition resulting in death)

106 East Church St., Frederick, Md 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ardiovascular Disease Hitheroscleratio Due to (or as a consequence of) Due to (or as a consequence of): Due to (or as a consequence of)

Physician/Medical 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 9 Unknown

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death

3 Ectopic pregnancy 5 ☐ Other (specify) 9 Unknown

23d. Date of delivery Month Day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No

1 ☐ Yes

6 ☐ Other (Specify)

Year

24b. Were autopsy findings available prior to completion of cause of death?

24a. Was an autopsy performed

				1 Li Yes 2
Was case referred to medical			26. Pla	ace of Death (Check only one)
examiner? Yes 2 □ No	Hospital: 1 ☐ Inpatient	2 ER/Outpatient	3 ☐ DOA Other: 4 ☐	Nursing Home 5 ☐ Residence
Manner of Death	28a. Date of Injury	28b. Time of	28c. Injury at	28d. Describe how i

27. 5 Pending investigation (Month, Day, Year) Natural 2 ☐ Accident 6 ☐ Could not be 3 Suicide

М

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certifie

29c. License number D 37197

29d. Date signed (Month, Day, Year) January 29, 2009

Name and address of person who completed cause of death (Item 23a) (Type,

ONY

State Registrar

State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	State of Maryla			of Death	nemarin	Reg. No.		USI	רדח
	1.5.		1. Decedent's Name (First, Middle, Last)			-		2. Date of D	eath Day	Year	3. Time o	Death
20	Physicia Medic		Michael	Leo	Dye	r		Jan. 1		2009	1:06	РМ
	Examin	_	4a. Facility Name (If not institution, give s	street and number)		1	n, or Location of Death		4c.	County of Death	1	
		- 3	5801 Nicholson Lar	ie	- Is a 4 frieth doub	Rockv If Under 1 Y		8. Date of Bi	et in	Montgome	ry place (State	or Fornian
п	Funeral		5. Social Security Number 6. Sex		7.5 Yrs.		ays Hours Min.	June	a <i>y, Year)</i>	Cot	intry)	
	Director	-	Usual Residence of Decedent		, ,			June	20,	1933 Ne	w York	
	yland now at		10a. State 10b. County	10c.	City, Town or Lo	ecation					10d. Inside C	
	a-f st	ctor	Md. Montgo	omery	Rockvil	L1e					1 <u>k</u>]Yes	2 No
	or 28	Dire	10e. Street and Number			10f. Zip Co			•	izen of What Co	untry?	
	ath w	Funeral Director	5801 Nicholson I				852			JSA	ione Indian	
	er de	nue	11. Walta Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent If Yes, specify	of Hispanic Origin? (Sp Cuban, Mexican, Puerto	ecity Yes or N Rican, etc.)	0-	14. Race - Amer Black, White		
36	rs aft I', or i	by F	1 ☐ Never Married 2★ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 □ Yes 2🏻	No Specify:	Specify: White				
Maryland 21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	Completed by	15. Decedent's Edu	cation	16a. Dece	dent's Usual O	ccupation		16b. K	ind of Business/I	ndustry	
215	hin 7; e. an "n Medi	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use r	one during most of worl etired)	ang				
2	yd wit ygiene er tha , the	5		5+	Analy	tical	Engineer			BM & Dyc	on	
nd	be filk tal Hy d oth	Be (17. Father's Name (First, Middle, Last)				18. Mother's Nam		e, Maiden	Surname)		
yla	ould Men Men narke	၉	Edward Dyer					Kyle				
Nar	12 sh hand 7 Is ⊓ trauπ		19a. Informant's Name/Relationship (Ty	rpe. Print)		,	reet and Number or Ru				ip Code)	
e,	1 and Health em 27 ther 1		Gregg Dyer/Son 20a. Method of Disposition	201	Dione of Dione	neition (Mama	Street Ke	nsingto Date		ocation - City or	Town, State	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at one.		1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	Removal from State G	cemetery create of I	matory or othe Heaven	Jan.	00 ²¹ ,	Silv	er Spri	ng,Mary	yland
Ħ	nit. Partme	H	21. Signature of Feral Septice Cons		2:	2. Name and A	ddress of Facility De	Vol Fur	eral	Home		
B	Dep Imp any		I have A Del	W	22	222 Wis	consin Ave.	, NW	Wasl	n., D.C.	20007	
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	lications that caused the d	eath. Do not en	ter the mode o	dying, such as cardiac	or respiratory	arrest,		Approxima Interval Be	ite etween
	Physician	V 1	Immediate Cause (Final disease or condition	Metastati	c Lung	Cancer					Onset and	Death
1	/Medical		resulting in death)	Due to (or as a cons								
E	Examiner		Sequentially list conditions.	b								
-	ed sit	ine	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as a cons	sequence of):					.53		
_	ificate be executed g physician and as the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a cons	sequence of):							
68760,	sician buria	alE		d								
687	tificate ig phy as the	edical		u								
Box	eath cert attending for use a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pre 1□Live birth 2□F		Testania progr	acres.			23d. Date of deli	ivery	
_	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of		_lEctopic pregi ☐ Other (speci				Month	Day	Year
P.0	requires that the death cert een signed by the attendin hould be detached for use a	Physician/IV	9 Unknown								7-0-7	1 0
	res tha igned be de	by F	Part II. Other significant conditions co	ntributing to death but not	resulting in the u	inderlying caus	e given in Part I.			use contribute to □ No 3□ Pr		
ord	w require	ted							1165 2			
Sec.	aw as b	Completed						24a. Wa	s an opsy formed?	24b. Were au prior to death?	topsy findings completion of	s available cause of
alF								1□ Yes	2 🔀 No	1 ☐ Yes	2□ No	
or Vital Records,	Physiclan; Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	T 50/0. t	00000	26. Place of Dea			• Flore 10		
or	Phys r this ral di	5 F	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury	2 ER/Outpatie		4 ☐ Nursing H Injury at Work?	28d. Describe		6 ☐Other (Specing occurred	city)	
on	Attending I r death. ector After by the funer	tio	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year	r) Injury	м	Work? 1 ☐ Yes 2 ☐ No					
Division	or Attendate are death	ifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - A building, etc. (Sp	at home, farm, st	reet, factory, o	ffice	28f. Location City or T	(Street a	nd Number or Ru	ıral Route Nu	mber,
Ö	- 무료등	Certification:		Januari gy etar (ep								
	e Hospital or 24 hours ar e e Funeral Dir letely filled in I	edical		rsician: To the best of my iner: On the basis of exan and manner stated.								(s)
	To the Hosp within 24 ho To the Fune completely f	Mec	29b. Signature and title of certifier			29c. L	cense number		29d. Da	ate signed (Monte	h, Day, Year)	
			* The Mar	5		D	26571		Jan.	19, 200)9	
	10	H	30. Name and address of person who	mpleted cause of death (Item 23a) (Type	, Print)						
_			Irving Mizus, MD	10605 Conco	ord St.		00 Kensing	ton, MI	208	95		
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Si	ignature	bout 9						
	Regist	re li		CE-UM	- Not : 350	- SW 107						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-00408 State of Maryland / Department of Health and Mental Hygiene Kenneth Alvin Dunwell 2009 03078 Certificate of Death 1- For State Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day January 14, 2009 1514 hrs **Medical Examiner** Kenneth Dunwell 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Suitland 4400 block of Suitland Road 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State of If Under 24Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number **Funeral** oreignJamica Days Months Sept. 14,1958 Country * M Director 50 212-11-6249 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location * Yes 2 28a-f show Maryland Prince Georges Suitland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number notified at 20746 Jamaica West Indies 3956 Suitland Road 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black 12. Was Decedent Ever in U.S. Funeral 11. Marital Status items If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. must be Armed Forces? Never Married 2 Married Yes 2 * No 9 Yes 2 * No specify: Specify: Black 4 * Divorced Yes, Give Yea Widowed other traumatic event, the Medical Examiner "natural" ⋧ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) 72 other than more, MD 21215-0036
Pages I and 2 should be filed within 7
tent of Health and Mental Hygiene. Private 12th Construction Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nellie Williams marked o Earl Dunwell Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 is 5609 36th Place Hyattsville, MD. 20782 Earl Dunwell / Father 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Baltimore, crematory or other place) 1 * Burial 2 Cremation 3 Removal from State Jan.24'09 Adelphi, Maryland George Washington ment c Other Specify Donation 5 3831 Georgia Avenue, N.W. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Latney's Funeral Home Washington, D. C. 20011 MD#278 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure, List only one cause on each line Death (Madica) a Multiple Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last requires that the death certificate be executed Physician/Medical AMENDED physician a LINPENDED Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy Day Year 23b. Was decedent pregnant in the past 12 months? Month Live birth Fetal death 3 Ectopic pregnancy Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown q Unknown the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. Yes 2 ✓ No 3 Probably 4 Unknown ≥ Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? this certificate has ✓ Yes 2 1 🗸 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: 24 hours after death. Division of Vital Be Hospital: 1 examiner? Other, Nursing Home 5 Residence 6 V Other: Scene Inpatient ER/Outpatient 3 DOA 1 🗸 Yes No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) Jan 14, 2009 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death Driver auto auto collision Certification: Yes 2 ✔ No Natural Pending Director: d in by the f 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc in by 3 Could not be or Town State Suicide 4400 block of Suitland Road, Suitland, MD determined (Specify) Major Road / Highway Funeral Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ga 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the and manner stated ٥ 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier January 15, 2009

Registra DHMH 17 Rev 1/2001

OCME 2006

State

OCME

Assistant Medical Examiner

Registrar's Signat

30. Name and address of person who completed cause of death (Item 23a)

Donna M. Vincenti, MD

JAN

31. Date filed (Month)

ORIGINAL

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Jan. 2009 **Physician THERESA** DeMARCHI 19^{ay} 9:15 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Montgomery Village 19319 Transhire Rd. If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🖾 F New York 93 April 26,1915 Director 083-05-7129 Usual Residence of Decedent 10d. Inside City Limits 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, the Modical Examinar must be notified at 1 ☐ Yes 2 ☑ No Director Montgomery Village MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20886 United States 19319 Transhire Road Funeral 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 K No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ KNo Specify ģ White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygienn Important: If item 27 is marked other tha any Injury or other traumatic event, ITeM Clerk Nursing Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Philomena Romano Anthony DeMarchi ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 19319 Transhire Road Montgomery Village, MD 20886 Nina DeMarchi(Niece) Baltimore, Jan.26 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ABurial 2 ☐ Cremation 3 🔀 Removal from State 2009 Hawthorne, New York Gate of Heaven Cemetery 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility DeVol Funeral Home 21 Signature of Funeral Service Licenses 10 East Deer Park Drive Gaithersburg, MD. 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Years **Physician** Congestive Heart Failure disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Years Atherosclerosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed and burial-tra Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the as use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Por Day 5 Other (specify) P.O. | the 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Atrial Fibrillation Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 KResidence 6 Other (Specify) Hospital: 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes မ this 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Certification: Injury 1X Natural 5 ☐ Pending investigation he Hospital or Attendin n 24 hours after death. He Funeral Director: Aft oletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a Certifier Medical To the Hosp within 24 ho To the Fune completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2 January 19, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 19241 Montgomery Village Ave. Montgomery Village, Cheryl E. Winchell M.D. 31. Date filed (Month, Day, Year) JAN 21 2 2. Registrar's Signature State

Registrar

DHMH 17 Rev 1/2001

ack

		1	For State Registrar		partment of F Pertificate of			leg. No. 2 1 1 (03080
			1. Decedent's Name (First, Middle, Last)				2. Date of Dea	th	3. Time of Death
	Physicia	ın	Antonia Imbesi D'Ascoli				Month January	Day Year 16 2009	NA
and a	/Medic		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	r Location of Death	January	4c. County of Dea	
	Examin	er	Suburban Hospital		Be	thesda		Montgom	nerv
	Funeral		5. Social Security Number 6. Sex 7. Ag	je (In yrs. last birthda	y) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day		rthplace (State or Foreign Country)
	Director		075-36-6316 1□ M 2XF	77 Yrs.	Months Days	Hours Min.	May 8,		alv
			Usual Residence of Decedent			1			
Ì	ylang		10a. State 10b. County	10c. City, Town or	Location				10d. Inside City Limits
3	Mar Mar	ķ	MD Montgomery	Mo	ontgomery	Village			1 ☐ Yes 2 X No
4	r 288	Director	10e. Street and Number		10f. Zip Code		1	10g. Citizen of What C	ountry?
1	23a o	at D	19026 Capehart Drive		2088	36		United St	ates
1	ms,	Funeral	11. Marital Status 12. Was Decedent Armed Forces?	Ever in U.S. 13	3. Was Decedent of h If Yes, specify Cub	Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Am Black, Wh	
ا و	or ite	교	1 ☐ Never Married 2 【X Married 1 ☐ Yes 2 【X If Yes, Give	No	1 □Yes 2 XNo	Specify:			hite
93	ali, c	by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		12100 22210			opeony.	
2-C	natul	etec	15. Decedent's Education (Specify only highest grade completed)	I (Gi	cedent's Usual Occup we kind of work done	during most of work	ing	16b. Kind of Busines	s/Industry
2	thin ie.	npl	Elementary/Secondary (0-12) College (1-4or	5+) life	. DO NOT use retire	d)		T to d	Dogganatino
21	ygier ygier ier th	Completed	5	Cust	om Drapery				Decorating
nd	tal H d oth	Be	17. Father's Name (First, Middle, Last)				e (First, Middle, . na Camin	Maiden Surname)	
<u>ya</u>	Men Men arke	၉	Gaetano Imbesi	T T					
a	permit. Pages 1 and 2 should be flied within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I fleem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Modical Examiner must be recitived at once.		19a. Informant's Name/Relationship (Type. Print) Fortunato D'Ascoli/ Husban					er, City or Town, State	ge, MD 20886
, Z	and ealth m 27 ner tr							20c. Location - City of	
ore	of H		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State	1	position (Name of rematory or other pla	Janua	ary 23	•	
<u>E</u> ,	Pag ment ant: I ury c		4 Donation 5 Dother (Specify)	Holy Cr	oss Cemete	ery 200	09'	Colma, CA	1
at	mit.		21. Signature of Funeral Service Licensee		22. Name and Addre	ess of Facility	. 10 Eas	t Deer Par	k Drive.
m	205 20		TRAMA. STUVEN		Gaith	iersburg,	MD 2087	7	,
			23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each I	d the death. Do not o	enter the mode of dyi	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between
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	7. +	ner	Sequentially list conditions, if any leading to immediate cause. Enter I Indentying.	a consequence of):					Î
)	cuted nd ransi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events						
oʻ	e exe ian al ırial-t		resulting in death) Last Due to (or as	a consequence of):					
68760,	ficate be executed physician and s the burial-transit	edical	d						
89	ng pt	Med	IF FEMALE:				and the second		
Вох	eath certifi attending for use as	an/l	23b. Was decedent pregnant		3 ☐ Ectopic pregnan	су		23d. Date of o	lelivery Day Year
<u>.</u>	ed fo	sici	1 Linknown	at time of death	5 Other (specify)			Monar	Day Tour
P.0.	Attending Physician: The law requires that the death certif radeath radeath ar death ar death. sctor: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	Physician/M	9 Ll Unknown		V 1. 1	and to Don't I	220 Did to	phono uno contributo	to the cause of death?
Ś	signed	by	Part II. Other significant conditions contributing to death	but not resulting in the	e underlying cause gi	ven in Part I.			
Records,	w requir s been si should I						1 1 1	res 2 No 3	Probably 4 X Unknown
၁၁	e law ro has be e 2 sho	Completed					24a. Was autop		autopsy findings available o completion of cause of
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ital	lan: rtifice tor, p	BeC	25. Was case referred to medical			26. Place of Dea			
>	yslc is ce direc		examiner? 1 ☐ Yes 2 🎇 No Hospital: 1 ☐ Inpat	ient 2 🛚 ER/Outpa	tient 3 ☐ DOA Ot	her: 4 □ Nursing H	ome 5 Resid	dence 6 □Other (S	pecify)
0	g Ph terth veral	딭	27. Manner of Death 28a. Date of In (Month, D			ıry at rk?	28d. Describe h	now injury occurred	
<u>ö</u>	ndin ath. r: Aff e fur	atio	1 Matural 5 Pending (Month, D 2 Accident investigation	,		Yes 2 □ No			
Division of Vital	Atte er de ecto by th	iţi	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Ir building, €	njury - At home, farm,	street, factory, office		28f. Location (S City or Tox	Street and Number or vn, State)	Rural Route Number,
ā	al or s afte al Dir	Certification: To							
	To the Hospital or Attending Physician: The I within 2 Hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page.		29a. Certifier 1 Certifying Physician: To the bes	t of my knowledge, do	eath occurred at the	time, date and place opinion, death occu	e, and due to the	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
	he H in 24 he Fi plete	Medical	one) and manner s						
	To the R within 2 To the I complet	Σ	29b. Signature and title of certifier		29c. Licen	24174		29d. Date signed (Mo	
			1 John		P	17179		1/19/2	009
	_		30. Name and address of person who completed cause of	death (Item 23a) (Typ	pe, Print)			NE 0001/	
			Robert Rothstein , M.D., 8		eorgetown	Road, Be	thesda,	MD 20814	
	Sta	ate	31. Date filed (Month, Day, Year) 32. Regis	trar's Signature	to Kall				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	ne or maryiar			ate of D			g. No. 20	09	03081
ī	Physicia	an	1. Decedent's Name (First, Middle, Last)	G D					2. Date of Death Month		Year 009	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give street	C. Dorsey		4b. C	itv. Town, or I	Location of Death	January	4c. County		7:55 A M
	Examin	er	5460 Ruth Keeton Way			C	olumbi	.a			vard	
	Funeral Director		5. Social Security Number 6. Sex 180 M 2 Usual Residence of Decedent	☐ F 7. Age (In yrs. 93	last birthda Yrs.	y) If Un Mont	der 1 Year hs Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Feb 23,	^{Yea} r) 1915	Cour	place (State or Foreign htry) Lington DC
	yland now		10a. State 10b. County	10c. Ci	ty, Town or	Location					1	0d. Inside City Limits
	e Mar Ba-fsh	ctor	MD Howard		Columb							1 Yes 2 No
	a or 2	Funeral Director	10e. Street and Number 5460 Ruth Keeton Way				Zip Code 21044		10	g. Citizen of W United		•
	ms 23	nera	11 Marital Status 12. W	as Decedent Ever in U	J.S. 13			spanic Origin? (Spanic American, Puerto	ecify Yes or No-	14. Race	- Americ	an Indian,
21215-0036	172 hours after death with the Maryland "natural", or items 23a or 28a-f show idical Examinar mast be moffled at	þ	1 Never Married Married 1	med Forces?]Yes 2 ½ No ′es, Give ar or Dat <i>e</i> s:			specity Cubar s 2 ∑ No	Specify:	Hican, etc.)	Specify:	k, White, o	
15-C	"natu	Completed	15. Decedent's Education (Specify only highest grade com	oleted)	1 (Gi	ve kind of	Isual Occupa work done di T use retired)	uring most of worki	ng 1	6b. Kind of Bu	siness/Ind	dustry
212	I within 72 giene. r than "na the Medic	omo	Elementary/Secondary (0-12) Co	llege (1-4or 5+)			Mecha			Automob	oile	Dealership
	be filed tal Hygi d other event, I	Be C	17. Father's Name (First, Middle, Last)					18. Mother's Name	•	aiden Surnam	е)	
Maryland	d 2 should thand Men Thand Men 7 is marked traumatic	မ	Glenn C. Dorsey, Sr. 19a. Informant's Name/Relationship (Type. Pr	int)	10h Ma	iling Add	oon /Stroot o	Eva Mil		City or Town	Stata Zin	(Cada)
	7 is		Frederick W. Dorsey/S			-		e Columb			olale, zip	(000e)
Baltimore,	ges 1 t of H If iter or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Remov	ai from State	Place of Dis cemetery, ci		Name of or other place			oc. Location - Hanover	•	
altin	permit. Pag Departmen Important: any Injury once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	M0104								ly FH Inc.
n	82 = 29		Don Ollins	regio		4112	01d C	olumbia 1	Pike Ell:	i∞tt C		MD 21043
	Physician		23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cau Immediate Cause (Final disease or condition resulting in death)	RTERIOS	SCLES	2011		ARDIOVI	tscuca.	R D	18EA	Approximate Interval Between Onset and Death
	/Medical Examiner			Due to (or as a consec	quence of):							0
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consec	querice of).							
o	rificate be executed ng physician and as the burial-transit		that initiated events c resulting in death) Last	Due to (or as a consec	quence of):						-	
68760,	icate be physici the bu	edical	d									
. Box	eath cer attendir for use	Physician/Me	in the past 12 months?	yes, outcome of pregn ☐ Live birth 2☐ Feta ☐ Pregnant at time of ☐ Unknown	al death	3 🗌 Ectop 5 🔲 Other	ic pregnancy (specify)			23d. Date Mor	e of deliventh	ery Day Year
О	hat the	Phys	9 ☐ Unknown Part II. Other significant conditions contribut		sulting in the	underlyir	n cause nive	n in Part I	23e. Did tob	acco use contr	ibute to th	ne cause of death?
rds,	w requires that the designed by the should be detached	ed by	ADULT FAILURE		THRI	VE	,			s 2 No		1.
Vital Records,	e la has e 2	Completed				<u></u>			24a. Was an autopsy perform 1 □ Yes 2	egi? d	Vere auto rior to co leath? Yes	psy findings available mpletion of cause of
/ital		BeC	25. Was case referred to medical examiner?					26. Place of Deati	(Check only one)		
ŏ	Physi r this c ral dire	မ	1 ☐ Yes 2 No Hospita	al: 1 ☐ Inpatient 2 ☐ a. Date of Injury	ER/Outpat		DOA Othe	4 Nursing Ho	me 5 Resider			y)
ion	nding ath. r: Afte e fune	ation	Natural 5 Pending 2 Accident investigation	(Month, Day, Year)	Injur		Work'	?	EGG, BOSONISO NO	, mary dodanie	J G	
Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28	e. Place of Injury - At h building, etc. <i>(Sp</i> ec	nome, farm,	str <i>ee</i> t, fac	tory, office		28f. Location (Str City or Town,	eet and Numbe State)	er or Rura	I Route Number,
	e Hospit 24 hour e Funera	Medical (29a. Certifier (Check only one) 1 Certifying Physician 2 Medical Examiner: Cartifying Physician 2 Medical Examiner: Cartifying Physician 2 Certifying Physician									
	To th within To th	Me	29b. Signature and title of certifier	Pa10000 0	w)		29c. License	number	29	od. Date signed	(Month,	Day, Year)
(300		30. Name and address of person who complete		m 23a) (Typ		Dd/	Hunt Val	lee M	100	07	1
	Sta	te	Stendage R Hauliner My 31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	1		LIDIN VO		<u> </u>		6
	Registr	ar	JAN 2 2 2009	Knewas	12. 1	gear	20				_	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day DEREMER 33 W **Physician** /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1□ M 2 N Months 220-30-7992 79 03/03/1929 Cumberland, MD Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at Anne Arundel 1 ☐ Yes 2 No MD Annapolis Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21409 570 Bellerive Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married "natural", or 1 ☐ Yes 2√☐ No Specify: White þ 3√ Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygien Important: If Item 27 is marked other tha any injury or other traumatic event. the the 08 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cope Llewlyn **Ethel** Gephart ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Firlie Daughter 480 Mountain Road Crownsville, MD 21032 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Atlantic Crematory 1/20/09 Glen Burnie, MD 4 Donation 5 Other (Specify) 21. Signature of Euneral Service Licensee 22. Name and Address of Facility 21401 Hardesty Funeral Home P.A. 12 Ridgely Ave Ann, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) RIAL FIRRILLATION lei Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and Due to (or as a consequence of) attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month jo 5 Other (specify) signed by the a 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performed certificate 2□ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1.☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 🗌 Yes P this funeral 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Certification: (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. To the Hospital or Attendi within 24 hours after death.

To the Funeral Director; A completely filled in by the fu 2 Accident

the death certificate be executed Division or Vital Records, P.O. Box 68760, Physician: Attending

Baltimore, Maryland 21215-0036

MICHAEL 31. Date filed (Month, Day, Year) State JAN 2 Registrar

3 ☐ Suicide

29a Certifier

Medical

4 Homicide

29b Signature and title of certifie

6 ☐ Could not be

determined

Name and address of person who completed cause of death (Item 23a) (Type, Print) N

32. Redistrar's Signature arke

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 17 Rev 1/2001

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

TONAPOLT MONYN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month / 9 / 2009 Year **Physician** 6:45pm M John Francis Doherty /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Collingswood Nursing & Rehab Rockville Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Days Months Hours 83 1 X MM 2 □ F 030-12-7984 12/19/1925 Mass Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes XX No Director Anne Arundel Odenton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21113 508 Gladhill Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 Yes 2 ☐ If Yes, Give Year or Dates: ^{2□No} Vietnam White 1 □Yes 2XXNo Specify: ≥ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) U.S. Army 12 Sgt. Major 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anna F. McGrath Cornielius C. Doherty 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Washington, DC 20009 1674-C Beckman Place NW Mike Doherty 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/2/2009 Arlington National Arlington, VA 21. Signature of Funeral Service Lice 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiac arythmia disease or condition resulting in death) Due to (or as a consequence of): Congestive Heart Failure Sequentially list conditions Due to or as a consequence of

Physician /Medical **Examiner**

> and burial-trar

physician

the

attending pl

sate has been signed by the page 2 should be detached

director.

this funeral

After

nours after death.

neral Director: Af
filled in by the fu

24 hours a

within 24 hor To the Fune completely f

Department of Health Important: If item 27 any injury or other tr. once.

Funeral

Director

28a-f show

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Experiment for colline.

Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or iten

altimore, Maryland 21215-0036

death with the Maryland

Examiner Physician/Medical 2 Be Completed Certification: To

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death

Due to (or as a consequence of)

4 Pregnant at time of death 5 ☐ Other (specify)

3 🗆 Ectopic pregnancy

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24a. Was an performe

1 ☐ Yes 2 No

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

Day

Year

25. Was case referred to medical examiner? 1 Yes 2 XNo 27, Manner of Death 1 Natural 2 Acciden

3 Suicide

29a, Certifier

4 🗌 Homicide

(Check only

5 Pending investigation 6 ☐ Could not be 28a. Date of Injury (Month, Day, Year) 28b. Time of 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 41 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29b. Signature and title of certifier

29c. License number Dooled 435 29d. Date signed (Month, Day, Year) 1/15/2009

23d. Date of delivery

Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital

S. Elsayyad 10110 Molecular Dr. Ste 206 Rockville, MD 20850

State Registrar

Medical

31. Date filed (Month, Day, Year) JAN 2 0 2009



and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 03084 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 19, **Physician** Melba Kramer Downey 2009 January 0110 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 19, 1 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) A **Funeral** Days Months Hours Min. Yrs 93 170-32-1709 1915 United States Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☐ No Maryland Frederick Monrovia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 28016 Barnes Road 21770 United States Funeral items ? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Extra Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify White Specify: þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George R. Kramer Bessie Dilliner ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George K. Downey - Son 8101 Riverside Ave, Cabin John, Maryland 20818 20b. Place of Disposition (Name of Green County) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State Jefferson, Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) Memorial Park Stauffer Funeral Home 21. Signature of Funeral Service Licensee 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Colon Carcinoma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖸 No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 🔯 No 3 ☐ Probably 4 ☐ Unknown Pneumonia, Intra abdominal abscess, acute renial Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an failure cate has by autopsy performed? Yes 22 No certificate 1 ☐ Yes I or Attending Physician: after death. 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Division of Vital Records, P.O. Box 68760 DOWNEY, MELBA OI/19/12009/ 01/10

within 24 hours aft To the Funeral Di completely filled in 5

Director:

State Registrar

Medical

mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 ☐ Could not be

3 ☐ Suicide

29a. Certifier (Check only one)

4 Homicide

29b. Signature and title of certifier

Robey, 8218 Wisconsin Ave., Bethesda, Maryland 20814 32. Registrar's Signature 31. Date filed (Month,

Story Branch and

and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D 50113

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1/19/2009

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene, 03085 For State Registral Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** $\mathbb{A}^{\ M}$ Sharon Lynn Davis 2009 3:00 January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Memorial Hospital Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Manthe Days Hours Min. (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 F Hours 16, Yrs. Ĩ956 Maryland July 52 **Director** 219-66-2740 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Middletown Frederick Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 118 Ivy Hill Drive 21769 Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If item 27 is marked other than "natural", or ite 1 Never Married 2 X Married 10, altimore, Maryland 21215-0036 White 1 ☐ Yes 2 🛣 No þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Child Care Provider Daycare 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 27 is marked or traumatic ever John R. Bowers Dorothy Gorman 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 118 Ivy Hill Drive, Middletown, MD 21769 Wayne Davis / Husband permit. Pages 1 and 3 Department of Health Important: If item 27 any Injury or other tr. once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 1/22/2009 Frederick, Maryland Stauffer Crematory 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Funeral Home 21. Signature Funeral Service Licenses 22. Name and Address of Facility 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part Enter the disease, or complications that cause a fee death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on expire. Approximate Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to inmodulate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) Division of Vital Records, P.O. certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 NUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 □No 2 No 1 ☐ Yes 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2⊠No Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident Injury 5 Pending i Director: A ed in by the fu 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a

To the Funeral I

completely filled 29a. Certifier 1 🗷 Certifying Pthysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number 01-20-0 MDD62471 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

Ghulam Abbas,

31. Date filed (Month, Day, Year)

MD

JAN 22

Frederick, MD 21701

400 West 7th Street,

32. Registrar's Signature

arest 1

State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 29 **Physician** JANUARY 2009 5:50AM DOVE INEZ JUANITA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CHARLES LA PLATA GENESIS LA PLATA CENTER 8. Date of Birth (Month, Day, Year) AUG • 10 , 1921 If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days Hours 1 □ M 2 12 1XE VIRGINIA 87 223-14-6735 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Evantinat must by notified at 1 No 2 No Director LA PLATA CHARLES MD 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number Pages 1 and 2 should be filed within 72 hours after death with NUMBER 1 MAGNOLIA DRIVE 20646 S. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: WHITE δ 3€Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) AT HOME HOMEMAKER 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SAMUEL PONTON MAE PURVIS ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a P.O.BOX 133 COBB ISLAND, MARYLAND 20625 DONNA PERRY/DAUGHTER other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition of FEBRÜÄRY 1 Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 Department of Important: If any injury or once. MD VETERANS CEMETERY 11,2009 CHELTENHAM, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility RAYMOND FUNL.SERVICE, P.A. re of Funeral Service License Oser M006415635 WASHINGTON AVE., LA PLATA, MD 20646 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician 1 UVANCO disease or condition resulting in death) /Medical Due to (or as a consequence Examiner CIVI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the burial-transit USON Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Year Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>≨</u> Probably 4 Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1∐Yes 2**X**ÎNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire completely filled in b Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29d. Date signed (Month, Day, Yea 29b. Signature and title of certifier Marrie and address of person mpleted ca use of death

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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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ysician		_{ame (First, Middle,} obert.	Joseph	Estes				Day Year 17, 2009	3. Time of Death 6:00 A
Medical aminer	4a. Facility Name	(If not institution,	, give street and number,	-	4b. City, Town, o	or Location of Death		4c. County of Death	0.00 h
	1775	Twirley		- da un tankhin		rince Fred		Calv	
eral ctor	5. Social Securit 085–14		6. Sex 7. Ag	ge (In yrs. last bird 86	Yrs. Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye 04/19/19)	ar) 9. Birthi Cou.	place <i>(State or Fore</i> ntry) York
	Usual Residence	7-					04/15/15/	(6) -	
any Injury or other traumatic event, the Medical Examinar must be netified at once. To Be Completed by Funeral Director	10a. State	10b. County	C = 1 +	10c. City, Towr		1 . 1			10d. Inside City Lim 1 ☐ Yes 21 ☐ 1
iner must be notified Funeral Director	MD 10e. Street and		Calvert		Prince Free	derick	10g.	Citizen of What Cou	
al D	1615	M. I.	Bowen Road		20	0678		U.S.A.	
in let	11. Marital Statu		12. Was Decedent Armed Forces	?	13. Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Spe an, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	
by F	3 TWidowe	arried 2□ M <i>a</i> rrio d 4□ Divorced	If Yes, Give Year or Dates:	1942-45	1 □ Yes 2 🛣 No	Specify:		Specify: W	hite
eted leaf	/S	15. Decedent	1		Decedent's Usual Occup (Give kind of work done		16t	. Kind of Business/In	dustry
r, the Medical E	Elementary/S	econdary (0-12)	College (1-4or	5+)	life. DO NOT use retire	ed)	'y	C+-+ 6	M - 1 1
e Co	17. Father's Nar	ne (First, Middle, L	Last)		engine		(First, Middle, Maid	State of	Maryland
atic even To Be	Edwar	d Howa	ard Este	S		Lucille	Vera	Truesd	e11
anma	19a. Informant's	Name/Relationsh		19b.	Mailing Address (Street	t and Number or Rura	l Route Number, Ci	ty or Town, State, Zij	o Code)
ther tr		t H. Est	es, son		775 Twirley				
or o'		2 Cremation	3 Removal from State		Disposition (Name of y, crematory or other pla			Location - City or To	
in in ini		n 5 □ Other <i>(Sp</i> FFuneral Service L		Highla	and Park Cem	etery 06/	20/2009	Alexandri	La Bay, N
and		men.	19 Derbus	1	8325 Mt. I	Harmony La	ne, Owing	al nome, s. MD 20	736
	23a, Part 1. Ent shock, or	er the disease, or neart failure. List o	complications that cause only one cause on each I	d the death. Do r	not enter the mode of dyi	ng, such as cardiac o	or respiratory arrest,		Approximate Interval Between
ian	Immediate Cau disease or cond resulting in dea	dition	_a. Cho	langio	carcino	ma			month
ical ner	1000mily in doo		Due to (or as	s a consequence	of):				
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5 -		II) Last		s a consequence of	of):				
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ned for	in the past			at time of death	5 ☐ Other (specify) _			Month	Day Year
Phy			ons contributing to death	but not resulting in	the underlying cause div	ven in Part I.	23e. Did tobac	co use contribute to t	he cause of death
2 should be detached pleted by Physic					, , , - ,		1 □ Yes		bably 4 ☐ Unkno
completed				-7			24a. Was an	24b. Were auto	opsy findings availa
mo							autopsy performed	? death?	ompletion of cause 2 □ No
Be C		eferred to medical				26. Place of Death			
10	1 ☐ Yes 2		Hospital: 1 Inpat		tpatient 3 DOA	her: 4 Nursing Ho		e 6 NOther (Speci	(fy) Son's l
tune tion	1 Natural	5 Pending	g (Month, D	ay, Year)	njury Wo	rk?]Yes 2□No	28d. Describe how i	njury occurred	
by the	3 ☐ Suicide	6 ☐ Could n	ined 26e. Place of Ir	njury - At home, fa etc. <i>(Specify)</i>	rm, street, factory, office		28f. Location (Stree City or Town, S	t and Number or Run	al Route Number,
lled in by the funera Certification:									
= =	29a. Certifier (Check only one)	1 Certifyin 2 Medical ∣	g Physician: To the bes Examiner: On the basis	of examination an	e, death occurred at the t d/or investigation, in my	time, date and place, opinion, death occurr	and due to the caus ed at the time, date	se(s) and manner as and place, and due t	stated. to the cause(s)
etely jetely	29b. Signature	and title of certifier	and manner s	nateu.	29c. Licen	se number	29d.	Date signed (Month,	Day, Year)
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completely	1	ration	Patel		DOD!	59061		anvary o	$XU^{-1}, \alpha U$
completely	30. Name and a	ddress of person	who completed cause of	death (Item 23a)	(Type Print)	59061	0	anvary o	206
completely filled in by the funeral director, page Medical Certification: To Be Com	30. Name and a	address of person of Partel Month, Day, Year)	110 Hosp	death (Item 23a)	(Type Print)	59061	Prince	anuary a	rick 1

DHMH 17 Rev 1/2001

		For State		State	of Maryla		artment of F			ental Hy	giene Reg. No. 2	nna	03089
		Registrar 1. Decedent's Name ((First, Middle,	Last)			Tuncate of	Dealli		2. Date of De		JUJ	3. Time of Death
Physician		Patricia	a Anne	e Edging	ton				ect	Month	Day	Year	4:08 am
/Medica Examine		4a. Facility Name (If n					4b. City, Town, o	r Location	of Death	200/0201		ty of Death	1.
		Civista	Medi	cal CE	enter		La	Plat	ta		C	har	les
Funeral		5. Social Security Nun 577–58–342		6. Sex 1 □ M 2 □ √F		s. last birthday Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Mi <u>n</u> .	8. Date of Bir (Month, Da nuary 5	th ay, Year)	Con	place (State or Foreign intry)
Director	-	Usual Residence of D			80	113.			Jar	uary 3	,1929	Ei	ngland
aryland show			10b. County		10c. C	City, Town or L	ocation						10d. Inside City Limits
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vurs after death with the Maryla ral" or items 23a or 28a-f shov Examiner mast be rediffed af	Director	10e. Street and Numb					10f. Zip Code		-		10g. Citizen o		intry?
s 23a	ā	70 Villa	age Sti					602			US		
ter de item		 Marital Status Never Married 	1 2□ Marria	Armed F	cedent Ever in torces?	U.S. 13,	Was Decedent of H If Yes, specify Cuba	lispanic Ori an, Mexicar	igin? (Spe n, Puerto F	cify Yes or No Rican, etc.)	14. R a	ace - Ameri <i>a</i> ck, White,	ican Indian, , etc.
urs af	≥	3 X Widowed 4		If Yes, C Year or	aive		1 ☐ Yes 2 X No	Specify:			Spec	ify: V	White
72 ho	Сошріете	1: (Specify	5. Decedent's	Education grade completed	7)	16a. Dece	dent's Usual Occup	ation	t of workin	a a	16b. Kind of I	Business/Ir	ndustry
ithin ne.	Ē	. Elementary/Second			(1-4or 5+)		kind of work done DO NOT use retired	d)	t or workin	g	_		
Hygie ther t	3	17. Father's Name (Fi	irst Middle I:			Man	nager	18 Mothe	ar'e Name	(First Middle	Reta , Maiden Surna		ept. Store
2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene. 1s marked other than "natural" or items 23a or 28a-f show raumatic event, the Modical Examinar must be recitled at	ן מֿ	William Mo		*						n Tye	, waiden odina	mej	
permit Pages 1 and 2 should be filed within 72 hours afti Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any in ury or other traumatic event, It a I witch Event once.		19a. Informant's Nam Patricia				19b. Maili 332	ng Address (Street South Ca:	and Number rolin	er or Rural a Av e	Route Numb			n DC 20003
of He of He rothe		20a. Method of Dispos				Place of Disponent	osition (Name of matory or other place	e)	Da	ate	20c. Location	- City or To	own, State
Pag ment ant: I ury o		4 Donation 5			Br	insfie	Ld-Echols	Crem	. 1/1	6/2009	Charle	tte F	Hall,MD
permit Depart Import any in		21. Signature of Fune	ral Service Li	Ehil	MO		AREHART-E					2064	46
		23a. Part 1. Enter the shock, or heart t	disease, or co	omplications that	each line	ath. Do not en	ter the mode of dyir	ng, such as	cardiac or	respiratory a		2005	Approximate Interval Between
Physician	ì	Immediate Cause (Findisease or condition		a	A	noxIC	Enceph	alop	all	4			Onset and Death
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7 +	2	Sequentially list condi if any, leading to imme cause. Enter Underlyi Cause (Disease or inju	tions, ediate	b	(or as a conse	· /	,						
ohysician and the burial-transit		Cause (Disease or injusted initiated events resulting in death) Las		c									
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physicials the bur	2		•	d									
attending properties for use as		IF FEMALE: 23b. Was decedent pr	rognant	23c. If yes, o	utcome of pregr	nancy					234 D	ate of deliv	(On)
hat the death certification of by the attending letached for use as	ysicia	in the past 12 mo	onths?		birth 2 Fet gnant at time of nown		☐ Ectopic pregnanc ☐ Other <i>(sp</i> ec <i>ify)</i>	у				onth	Day Year
that the hold by detact		Part II. Other significa	ant condition	s contributing to	death but not re	sulting in the u	nderlying cause give	en in Part I.	,	23e. Did to	obacco use cor	ntribute to t	the cause of death?
The law requires that cate has been signed to page 2 should be detailed.	2	Demen	tia, t	ty perten	5100	C0101	nderlying cause give	erial		1 🗆 ነ	res 2 □ No	3 ☐ Pro	bably 4 thknown
as be		dise	NIE,	myoca	ideal.	in faci	cf100			24a. Was			opsy findings available
sician: The law scertificate has be rector, page 2 s	5	DV	T							autor perfo 1 □ Yes	rmed?	prior to co death? 1 🗀 Yes	ompletion of cause of
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hysk this o		1 ☐ Yes 2 No)		Inpatient 2			4 ∐ Nu	rsing Hom	e 5 🗆 Resid	dence 6 🗆 O	ther (Speci.	fy)
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ital or Attending Physis after death. "al Director: After this led in by the funeral dil	Į.	4 Homicide	determine	ed build	ding, etc. (Spec	ify)	cor, ractory, office		-	City or Tov	vn, State)	ber or mura	ai Houte Number,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Medical Certification. To Be Completed the Diversities Medical Example		29a. Certifier 1 (Check only one)	Certifying Medical Ex	caminer: On the	e best of my kn basis of examir nner stated.	nowledge, deat nation and/or ir	h occurred at the tir vestigation, in my o	ne, date ar pinion, dea	nd place, a ath occurre	nd due to the d at the time,	cause(s) and r date and place	nanner as s	stated. o the cause(s)
To the within To the comp		29b. Signature and title	e of certifier	ndheum	ľ	-	29c. Licenso	e number	/ /		29d. Date sign		Day, Year)
	-	20 Name and all	0.01.0000000000000000000000000000000000	20.00==================================	una of death of	00-1 /7	V-6	101	7				, , , , , , , , , , , , , , , , , , , ,
81	1 orangement	30. Name and address	Simly	Completed cau	AD (m 23a) (Type,	Print) Ffice Rd	Sui	to 1	01 (11-	Mort	MD	20602
State		31. Date filed (Month,	Day, Year)	32.	Registrar's Sign	ature	lan Nad	-01	/		ALUI)		
Registrar		1	JAN 20	2009	Ensur	13. 19	Variation of the second						

Edginsten, Patricia MR-445442 Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 12:45 PM 2009 January Sheila Ann Evans /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **Elkridge** Howard 7050 Ducketts Lane #103 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug 17, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) Funeral Days Hours 1 □ M 2 🗓 F 1960 New York 48 Director 118-60-5971 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State d 2 should be filed within 72 hours after death with the Maryla th and Mental Hygiene. 27 is marked other than "natural", or Items 23a or 28a-1 show traumatic event, the Medical Examinating that willish at 1 ☐ Yes 2 No Director Pike OH Beaver 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 45613 1046 Bobo Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: þ 3√ Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Louise Kobre Edmund Robert Sullivan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any Injury or other trauonce. 7050 Ducketts Lane #103 Elkridge, MD 21075 Jamie Cain/daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Pages 1 1 Burial 2 Cremation 3 Removal from State Arundel Crematory 01/21/09 4 ☐ Donation 5 ☐ Other (Specify) Odenton, MD 22. Name and Address of Facility
Going Home Cremation Service P.O. Box
Beverly L. Heckrotte, P.A. Clarksville, 21. Signature of Funeral Service Box 784 11e, MD Devel 21029 The 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a Carcinoma of Unknown Primary with Liver Metastases **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2X No Month Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☑ No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) daugnter s Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? After t 1 Natural 5 Pending n 24 hours after death.

e Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospital 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D18320 January 20, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John H. Fetting, M.D. 10753 Falls Rd. Suite 415 Lutherville, MD21093 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State parke

DHMH 17 Rev 1/2001

Registrar

JAN 22

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra MFND#80er INF, 1/26/09, BMW, MoCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 16, 2009 PM January 4 Feldmann Norberto /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birt 8-29-1920 | 9. Birthplace (State or Foreign Months Days | Hours | Min. 12 (Months Days | Grant Research 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Min. 1.2 Cuba 578-40-2364 1 XM 2 □ F 88 Yrs **Director** Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f sho 1 X Yes 2 ☐ No Director MD Silver Spring Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2225 Ross Road 20910 United States · death v Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ☐Yes 2√☐No If Yes, Give Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White ρ 1 ☐ Yes 2 XNo Specify Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiens Important: If item 27 is marked other that any Injury or other traumatic event, in once. 12 Carpet Salesman Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Solomon Feldmann Fruma Shub ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2225 Ross Road, Silver Spring, Maryland 20910 Rosa Feldmann, wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
King David
Memorial Gardens 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 32 ☐ Removal from State 01/18/2009 4 ☐ Donation 5 ☐ Other (Specify) Falls Church, Virginia 21. Synature of Service Licensee 22. Name and Address of Facility
Danzansky-Goldberg Memorial Chapels, Inc. Danzansky-Goldberg remorial

1170 Rockville Pike, Rockvil

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1170 Rockville Pike, Rockville, Maryland 20852 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Renal Failure /Medical Due to (or as a consequence of) Examiner Bradycardia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami sician and burial-tran Due to (or as a consequence of): 68760, inding physician use as the burial the death certificate be Physician/Medical Box IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? atter for u 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No ed by the detached Ö 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 3 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 2 No certificate Vital 2 □ No 1 ☐ Yes 1 ☐Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2∑XNo 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ ð this eral Director: After th 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 ☐ Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital or Al 24 hours after of determined 4 Homicide e Funeral 29a. Certifiei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical within 2 To the 1 and manner stated.

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29b. Signature

30. Name and addre

31. Date filed (Mor

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BER

DMANN

Registrar DHMH 17 Rev 1/2001

State

8600 Old Georgetown Road, Bethesda, MD

leted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29d. Date signed (Manth, Day, Year)

20814

1 ☐ Yes 2 ☐ No

36766

1 Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

SetoN Drive, Cumberland, MD 21502

29d. Date signed (Month, Day, Year)

28a-f show **Physician** /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician a the burial-Box 68760. Ö signed by t ۵ Records, certificate Division of Vital this After Director: within 24 hours a

To the Funeral C

Physician

/Medical

Examiner

10a. State

Director

Funeral

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Completed

Be

2

Funeral

Director

Examine Physician/Medical ģ Completed Be Certification: To Medical

IF FEMALE:

2 Accident

4 Homicide

29b. Signature and title of certifie

30. Name and address of person who

3 Suicide

29a. Certifier

6 Could not be

2168

State Registrar

4

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated

completed cause of death (Item 23a) (Type, Print)

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State of Maryland / Department of Health and Mental Hygiene 2009 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 7:05 a 17, 2009 Forney January Marion /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner St. Mary's St. Mary's Nursing Center Leonardtown Trunder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🗓 F 579-07-6388 98 May 22,1910 Maryland Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State "natural", or items 23a or 28a-f show order Exeminer must be notified at 1 XYes 2 No Director MD St. Mary's Leonardtown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with to ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or items or other traumatic event, the Modical Exercitor is used by an or other traumatic event. 20650 USA 21585 Peabody Street Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify. White ≥ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Harvey Forney Margaret Cecelia Green ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau 11220 DeLozier Farm Rd. Newburg, MD 20664

ce of Disposition (Name of Date 20c. Location - City or Town, State Marie DeLozier/Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Christ Church Cemetery 1/22/09 Wayside, Maryland 4 ☐ Donation 5 ☐ Other (Specify) M00945 22. Name and Address of Facility Arehart-Echols Funeral Home, P.A. 21. Signature of Juneral Service Licensee David Kchok 211 St. Mary's Ave. La Plata, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** neumowa disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Demei Sequentially list conditions, Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 X No 5 ☐ Other (specify) 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? 1 Des 2 No 1 □Yes 2 □No 25. Was case referred to medical examiner? Be (26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Injury 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death. 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 19,0 H7066 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A.D. Shah, M.D. St. Mary's Medical Arts Bldg. Leonardtown, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 2 1 2009 Registrar

		-	For State Registrar Amend #23a&30	State of Ma CC Pre PHYS 1	iryland HD DI 26/09	Cei	artment of H rtificate of L	eaith and Death	Mental Hy	/gien Reg. N	e 20	09	03091
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Baltimore,	permit. Pages Department of Important: If it any Injury or once.		21. Signature of Funeral Service Lice	nsee	CC03	95 Na	2. Name and Address & Slav 089 James	ss of Facility V Funera	al Home	-			
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				MARYLA			2			titis				None			
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	rryland show	_	Usual Residence of 10a. State	Decedent 10b. County		10c. City	, Town or Lo	cation							10	Od. Inside (•
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lar.	uld be Jentz rked tic ev	To E	Nicholas	s Cornias						Con	stant	ina V	alis	5			
Maryland	12 should be fi h and Mental b is marked ot raumatic ever		19a. Informant's N	ame/Relationship (Type. Print)		19b. Maili	ng Addres	ss (Street a	and Number	or Rural I	Route Numb	er, City	or Town, S	State, Zip	Code)	
	1 and 2 Health tem 27 i		Konstan	t G. Foti	s / Spouse	€	5125	Forg	e Rd.	P	erry	Hall,	MD	21128	3		
ore			20a. Method of Dis		Removal from State	20b. P	lace of Dispo emetery, crea	sition (Namatory or	ame of other plac	e)	Dat	te	20c. l	_ocation - C	City or Tov	wn, State	
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tronce.		4 ☐ Donation	5 ☐ Other (Specify	1)	Oak	Lawn				/20/2	2009	Bal	ltimo	re, N	1D	
Bal	permit. Page Department of Important: if any injury or once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral 6512 NW Crain Hwy. Bowie, MD											5			
			23a. Part 1. Enter t	he disease, or confurt failure. List only	olications that caused the cause on each li	the death	n. Do not en	ter the mo	ode of dyin	g, such as c	ardiac or	respiratory a	rrest,			Approxima Interval Be	
-	Physician		Immediate Cause disease or condition	(Final	a IDIOP						_					Onset and	Death
- 3	/Medical Examiner		resulting in death)		Due to (or as						Α						
		ē	Sequentially list co	nditions,	b Due to (or as	a consedi	ience of).										
	uted d ansit	Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events	rlying injury	540 10 (01 40	a consequ	101100 017.										
Ć,	execunary an and ial-tra	Exa	resulting in death)	Last	Due to (or as	a consequ	ence of):								-		
68760,	rificate be executed ng physician and as the burial-transit	edical		•	d												
	rtifica ng ph as th		IE EEMALE.										T				
P.O. Box	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/N	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 21 9 ☐ Unknown	months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3	☐ Ectopic ☐ Other (pregnancy specify)	/				23d. Date Mon		ry Day	Year
	res that signed by be deta	by Ph	Part II. Other sign!	ficant conditions o	ontributing to death b	ut not resu	ılting in the u	nderlying	cause give	en in Part I.		23e. Did t	tobacco	use contrib	bute to the	e cause of	death?
ord	w require s been si should b	ted t				-						1 🔲	Yes 2	2 □ No 3	3 Proba	ably 4	Unknown
al Records,	/siclan: The law s certificate has b lirector, page 2 sf	Completed							-		_	24a. Was autop perfo 1 □ Yes		pr	ere autop ior to con eath? □Yes	osy findings npletion of 2 No	s available cause of
V:	Iclan certifi ector	Be	25. Was case refer examiner?		Hospital:				1011		of Death (Check only o	one)				
of Vital	Phys r this ral dir	₽.	1 ☐ Yes 2 N		11/UInpati		ER/Outpatie			4 🗀 Nur		5 🗀 Resi)	
Division	ending F aath. or: After the funera	ation	1 Natural 2 Accident	5 Pending investigation 6 Could not be		iy, Yea <i>r)</i>	28b. Time o Injury	M	28c. Injun Work 1 □	yat ?? Yes 2 □ N	1	d. Describe	how inju	ary occurred	d		
Divi	the Hospital or Attending hin 24 hours after death. the Funeral Director: After mpletely filled in by the funer	Certification:	3 ☐ Suicide 4 ☐ Homicide	determined	building, el	c." (Specify	<i>(</i>)	·	,		i	f. Location (. City or To	wn, Stai	te)			mber,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one)	1 Certifying Ph 2 Medical Exam	ysician: To the best niner: On the basis of and manner st	of examina	wledge, deat tion and/or ir	h occurre vestigation	ed at the tir on, in my o	ne, date <i>a</i> nd pinion, deatl	d place, ar h occurred	nd due to the	cause((s) and mar	nner as st nd due to	ated. the cause	(s)
	To the within 3	ž	29b. Signature and	title of certifier				2	9c. License	e number			29d. D	ate signed	(Month, L	Jay, Year)	
			42	DE MO	MERILL		Sypark		P	ZiZie	2		C	oc/le	120	'EG	
	56		(1	completed cause of		-		-	A		- ^ -		1			
	Sta	to	31. Date filed (Mon	Melean oth, Day, Year)	32. Redist	ar's Signal	GRE ture	ENE	T	8	TTM	ave	M	2	1201		
	Registr			JAN 202	2009	WE	1	book	1								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Beg No. 2000 Certificate of Death Physician /Medical Examiner **Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural"; or items 23a or 28a-f show amy injury or other traumatic event, I'm Medical Ever, from trailing 1 and once. Baltimore, Maryland 21215-0036 Fitzhugh,

> Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlal-transit

1 - State Registrar		Certific	ate of Death	Reg. No. 2009 03096					
1. Decedent's Name (First, Middle, Last)				1	3. Time of Death				
	Catherine Patricia Fi	itzhugh		Month	26 09	10:35 PM			
4a. Eacility Name (If not institution, give s	ico at the l	oke	ity, Town or Logation of I	bury	4c. County of Dea	omico			
5. Social Security Number 16. Security Number 109-18-0411	7. Age (In yrs.	Mont		Hrs. 8. Date of Birth (Month, Day, 12/6/1	Year) C	thplace (State or Foreign ountry) Wales, UK			
10a. State 10b. County	10c. Cit	y, Town or Location			10d. Inside City Limits				
Maryland Dorch	ester		Cambrid	ge		1 X Yes 2 ☐ No			
10e. Street and Number		10f.	Zip Code		g. Citizen of What C	ountry?			
	r Ave, #701		21613		U	SA			
The manual orange	12. Was Decedent Ever in U. Armed Forces?	.S. 13. Was De	ecedent of Hispanic Origin specify Cuban, Mexican, F	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Am Black, Whit				
1 Never Married 2 Married 3X Widowed 4 Divorced	1 ☐ Yes 2 📉 No If Yes, Give Year or Dates:	1 □Ye	s 2X No Specify:		Specify:	White			
15. Decedent's Educ (Specify only highest grade	cation e completed)	16a. Decedent's U	Jsual Occupation work done during most o Tuse retired)	f working	6b. Kind of Business	/Industry			
Elementary/Secondary (0-12)	College (1-4or 5+)	1	ality Control Speci	alist	Manu	facturing			
17. Father's Name (First, Middle, Last)				Name (First, Middle, M		inactai ing			
Wil	liam McClammy			Is	abel Pilar				
19a. Informant's Name/Relationship (Type		19b. Mailing Addi	ess (Street and Number			Zip Code)			
William R. Fitzhi	ugh / Son		5521 White	Hall Rd., Cambri	dge, MD 21613	3			
20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ R		Place of Disposition (cemetery, crematory	Name of or other place)	Date 2	20c. Location - City or	Town, State			
4 Donation 5 Other (Specify)		ern Shore Veter	ans Cemetery	1/30/2009	Hurlo	ock, MD			
21. Signature of Fund Service License	·		e and Address of Facility Bromwell Funeral	Home PA 308	High St. Cam	bridge MD 2161			
shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or a) (or	uence of):	ARDionyo ART P.	PATHY AILURIZ		Approximate Interval Between Onset and Death			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unkndwn	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of 6	ıl death 3 □ Ectop	ic pregnancy (specify)	_	23d. Date of de Month	elivery Day Year			
Part II. Other significant conditions cor	ntributing to death but not res	ulting in the underlyir	ng cause given in Part I.	23e. Did tob		o the cause of death?			
25. Was case referred to medical			26 Place of	24a. Was an autopsy perform 1 □Yes 2	death?	utopsy findings available completion of cause of s			
examiner? 1 ☐ Yes 2 ☐ No	lospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	Other:	ing Home 5 ☐ Reside	•	ecity) HOSPICIS			
27. Manner of Death .1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe ho					
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Special	ome, farm, street, fac	tory, office	28f. Location (Str City or Town	eet and Number or R , State)	ural Route Number,			
29a. Certifier Certifying Physical Examination (Check only one)	sician: To the best of my knowner: On the basis of examination and manner stated.	owledge, death occur ation and/or investiga	rred at the time, date and tion, in my opinion, death	place, and due to the ca occurred at the time, da	ause(s) and manner a ate and place, and du	as stated. e to the cause(s)			
29b. Signature and title of certifier			29c. License number ∂005 ₹	I .	Od. Date signed (Mon				
30. Name and address of person who co		n 23a) (Type, Print)	P.O ROK 1	737 SA	inues.	np 21802			
31. Date filed (Month, Day, Year)	32. Registrar's Signa		Sand!		10-/	- 77			

State Registrar

216

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 8:30 P M January 2009 Robert Galpeer 11, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bethesda Montgomery Suburban Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Months Days Hours Min. 1**X** M 2□ F 07/13/1923 New York Director 85 064-14-9455 Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene.

Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any lury or other traumatic event, the Medical Evarunar must be notified at once. 10a. State 10b. County 10c. City, Town or Location MD Rockville X Yes 2 □ No Director Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20853 Untied States 14300 Bauer Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1▼ Yes 2 □ No In Yes, Give Year or Dates: WW I Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐Yes 21 No Specify: Specify: White ģ 3 Widowed 4 Divorced WW II Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Department of the Navy Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ada Schwab William Galpeer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14300 Bauer Drive Rockvile MD 20853 Shirley Galpeer - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington Nat. Cemetery 4/6/2009 Arlington, VA 22. Name and Address of Facility vice Licenses Danzansky-Goldberg Memorial Chapels Inc 1170 Rockville Pike Rockville MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory af est shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Anoxic Encephalopathy /Medical Due to (or as a consequence of) Examiner Pneumonia Sequentially list conditions, any leading Limitation cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.0. certificate has been signed by the rirector, page 2 should be detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>\$</u> Aspiration of Foreign Body (Steak) 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2√2 No 1 ☐ Yes 2 √2 No ospital or Attending Physician: 1 hours after death. uneral Director: After this certifically filled in by the funeral director, pa 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XXYes 2 □ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death Date of Injury 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation 1 Natural 12/26/08 Choked on piece of steak 1 ☐ Yes 2 X No 2 Accident 3 Suicide 5:30 P 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide e Hospital of 24 hours all e Funeral D Rockville MD at home The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

10

To the I within 2

29b. Signature and title of

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State Registrar

Timothy N. Quast MD 8600, Old Georgetown Road Bethesda MD 20814

29c. License number

0101235548

29d. Date signed (Month, Day, Year)

15/2009

and manner stated.

32. Pagistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			For State Registrar	State of Mary		artment of H		, ,	giene leg. No. 2 N	19 03098
	Physicia	an	Decedent's Name (First, Middle, Las	t)				2. Date of Dea Month	th	3. Time of Death
	/Medic	al	Julio Goldent			4h City Town or	al antina at Da	January	17, 200	9 12:40 P ^M
	Examin	er	Montgomery Genera	· · · · · · · · · · · · · · · · · · ·		4b. City, Town, or Olney	Location of De	eatn	4c. County of	
П	Funeral		Social Security Number 6. S	7. Age (//	n yrs. last birthday)	If Under 1 Year Months Days	If Under 24 H	Hrs. 8. Date of Birth (Month, Day		Birthplace (State or Foreign Country)
	Director		112-32-7793	^{3 M 2 G F} 81	Yrs.	Working Days	Tiodis	03/05/1		Argentina
	land ow		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	cation				10d. Inside City Limits
	a-f sh	ctor	MD Montgome	ry	Silver S	oring				1 X Yes 2 □ No
	or 28	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wh	at Country?
	sath w	Funeral	15101 Interlachen			20906	ianania Origia?		SA	American Indian
130	be filed within 72 hours after death with the Maryland to Hygiene. Hygiene. do they than "natural", or terms 23a or 28a-f show event, the Medical Exeminar must be notified at	by Fun	11. Marital Status 1 ☐ Never Married 2 🕱 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Even Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Mas Decedent of H fYes, specify Cuba I∐Yes 2∏xNo	spanic Origin? an, Mexican, Pu Specify:	' (Specify Yes or No- lerto Rican, etc.)	Specify:	American Indian, White, etc. White
15-UU36	72 hou natura lical E	Completed	15. Decedent's Edi (Specify only highest grad	ication		dent's Usual Occup		warking	16b. Kind of Busin	ness/Industry
7	within / iene. than "r he Med	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	OO NOT use retired	daning most of v i)	NOTKING		
7	e filed w al Hygie I other tl vent, In		17. Father's Name (First, Middle, Last)	5+	Physi	<u>ician</u>	18 Mother's N	Name (First, Middle, I	Medical	
land	ld be lental ked o ic eve	o Be	Abraham Goldenber	g			Clara C	•	naioen camamo,	
ary	2 should be fi and Mental H is marked ot aumatic ever	-	19a. Informant's Name/Relationship (7			g Address (Street	and Number or	Rural Route Number		
, Ma	and 2 lealth m 27 i		Carlota Goldenber				chen Dr			ing, MD 20906
<u> </u>	ges 1 or of H or oth	N	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☑	Removal from State		natory or other plac			20c. Location - Ci	•
Бантітог	nit. Pa artmer ortant Injury		4 □ Donation 5 □ Other (Specify 21. Sign for of August Service License		National 22	Cremator	ium¦01/	19/2009	Falls Ch	urch, VA
ñ	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic ev once.		CANTO			DWARD SA 091 Rock	GEL FUN ville P	ERAL DIRE	CTION, II	NC.
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5	Physician		Immediate Cause (Final disease or condition resulting in death)	a. KESP	ITORY	CAIL	URE			Onset and Death
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		Jer	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	b. FCO1		ERLOA	0			
	ecutec ind transit	Examiner	that initiated events	· RENA		WFFIC	CENC	У		
6/60,	cate be executed physician and the burial-transit	a E	resulting in death) Last	Due to (or as a co	insequence of):					
199	ificate g phys s the	edical		d						
X D D	th cert ending	M/us	23b. Was decedent pregnant	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐		Ectopic pregnancy	.,		23d. Date of	of delivery
))	t the dea by the att ached fo	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at tim		Other (specify)	,		Month	n Day Year
s'	es tha igned be det	by P	Part II. Other significant conditions co			nderlying cause give	en in Part I.			ute to the cause of death?
ecords	requir	eted	CHF GX4C	ERBATI	510			_ 1 □ Ye	es 2 No 3	Probably 4 Unknown
al Rec	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use as	Completed	<u> </u>			·		24a. Was a — autops perfori 1 □Yes	ned? dea	re autopsy findings available or to completion of cause of ath? Yes 2 □ No
VII	slciar s certif irecto	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	0. T. E. P. C + - + - + - + - + - + - + - + - + -	t 3 🗆 DOA Othe		Death (Check only on		
on or	g Phy erthis eral d	μĬ	27. Manner of Death	28a. Date of Injury (Month, Day, Ye	2 ER/Outpatien	28c. Injur	y at	g Home 5 Reside	ow injury occurred	(Specify)
200	endin sath. or: Aff he fur	atio	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Wonth, Day, re	ear) Injury	M 1□	Yes 2 □ No			
DIVISI	al or Att s after do al Direct ed in by t	Certification: To	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (\$	At home, farm, stre Specify)	eet, factory, office		28f. Location (Si City or Town		or Rural Route Number,
	ne Hospit n 24 hour ne Funera	Medical (29a. Certifier (Check only one) 1 ☐ Certifying Phy 2 ☐ Medical Exam	rsician: To the best of miner: On the basis of ex and manner stated	amination and/or in	n occurred at the tin vestigation, in my o	ne, date and pla pinion, death o	ace, and due to the occurred at the time, d	ause(s) and manr ate and place, and	ner as stated. d due to the cause(s)
	Vithi Vott	Ž	29b. Signature and title of certifier			29c. License			9d. Date signed (
	3		Your MO		m == . :		0068	026	01/18/	04
			30. Name and address of person who of Dr. Padmaja Bandi	, 18101 Pri	nce Phili	p Drive,	Suite 3	315, Olney	, Maryla	nd 20832
	Sta Registra		31. Date filed (Month RN 121) 2	009 32. Registrar's	Signature .	and				

DHMH 17 Rev 1/2001

Baltimore. Maryland 21215-0036

			For	State of Ma		d / Depa	artment of	Health and	-	_	••
			Registrar 1. Decedent's Name (First, Middle	le l ast)		Cei	tificate of	Death	2. Date of De	Reg. No. 200	9,03100
	Physicia		Dottie	Lou	1	Gaugh	an-Kesne	er	Month 01	Day Ye 16 09	0340 M
	/Medic Examin		4a. Facility Name (If not institution	n, give street and number)			-	or Location of Deatl		4c. County of D	
			WMHS-BRADDOCH	CAMPUS			CUMBER			ALLEGAN	
	Funeral Director		5. Social Security Number 234–62–2860	6. Sex 7. Ag 1 ☐ M 2 🔀 F	e (In yrs. 67	last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Bir (Month, Da 09/27/	th 9. ay, Year) '1941 We	Birthplace (State or Foreign Country) est Virginia
	pu »		Usual Residence of Decedent 10a. State 10b. County		100 Cit	y, Town or Lo	action				10d. Inside City Limits
	f shov	ō	,	oshire	100. 010		omney				1 X Yes 2 □ No
	r 28a-	irec	10e. Street and Number		l		10f. Zip Code			10g. Citizen of What	·
	23a c	Funeral Director	185 N. Bolto				26757			USA	
	items	-une	11. Marital Status 1 □ Never Married 2 ☑ Mar	12. Was Decedent in Armed Forces?		S. 13. \	Was Decedent of f Yes, specify Cul	Hispanic Origin? (S ban, Mexican, Puert	Specify Yes or No to Rican, etc.)	o- 14. Race - A Black, W	American Indian, /hite, etc.
2	rurs af	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes Give **			I∐Yes 2M∏No	Specify:		Specify:	White
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2	il Hyg other /ent,	Be C	17. Father's Name (First, Middle,				Camb or Cr	18. Mother's Nar		, Maiden Surname)	<u> </u>
ylai	Duld be Ments arked	To E	Luther	Ben		Wolfe		Viola	Ma	arjorie ————	Poling
2	d 2 sh th and 7 is m traum		19a. Informant's Name/Relations Johhny B. Kesne					tand Number or Ri on Street		per, City or Town, State 7. WV 267	
5	f Heal		20a. Method of Disposition		20b. P		sition (Name of natory or other pla		Date	20c. Location - City	
2	Pages nent o ant: If ury or		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (5					dens 01/	19/2009	LaVale,	MD
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Evanirer must be notified at once.		21. Signature of Funeral Service	Licensee						nily Funer erland, MD	al Home, P.A. 21502
Ī			23a. Part 1. Sofer the disease, o shock, or heart failure. List	r complications that caused t only one cause an each lin	the death	h. Do not ent	er the mode of dy	ing, such as cardia	c or respiratory a	arrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. B-Ca	ell		uphor	MU			Few mouth
أم	Examiner			Due to (or as	a consequ	uence of)	l				
	p ±	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b Due to (or as	a consequ	uence of):					
	xecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):								
, S	e be er sician s buria	cal E	,	Dae to (or as	a conseq.	uci icc 01).					
3	rtificat ng phy as the	/ledio	IS SSMALE.								
	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	2 🗌 Feta	Ideath 3	Ectopic pregnan	су		23d. Date of Month	delivery Day Year
5	that the de ned by the a detached f	ıysic	1 ☐ Yes 2 No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	t time of c	death 5	Other (specify)				,
Ĺ	es that igned b	by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							e to the cause of death?	
Š	w require been signations been signated be								1 🗆	Yes 2 No 3□	Probably 4 Unknown
נו	e law has b je 2 sh	Completed							24a. Was		e autopsy findings available to completion of cause of
ğ	an: Th tificate or, pag		25. Was case referred to medica	al I				26. Place of Dea	1 □ Yes	2€2No 1□	
>	nysicia nis cer direct	To Be	examiner? 1 ☐ Yes 2 ☑ No		ent 2 🗆	ER/Outpatier	ıt 3□ DOA Ot	hor:		dence 6 ☐ Other (5	Specify)
	ing Pt	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pendir	28a. Date of Inju (Month, Da	ıry y, Ye <i>ar)</i>	28b. Time of Injury	Wo	rk?	28d. Describe	how injury occurred	
2	Attend death ctor: y the f	ficat	3 ☐ Suicide 6 ☐ Could	ningal 28e. Place of Init	ury - At ho	ome, farm, str		Yes 2 □No	28f. Location /	Street and Number of	r Rural Route Number,
2	al or A s after al Dire	Certification:	4 ☐ Homicide determ	building, etc	c.'(Specif	(y)	, , , , , , , , , , , , , , , , , , , ,		City or To		
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical (29a. Certifier 1 Certifyi (Check only one) 1 Medical	ng Physician: To the best I Examiner: On the basis o and manner sta	f examina	wledge, deatl ation and/or in	n occurred at the vestigation, in my	time, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and manne date and place, and	er as stated. due to the cause(s)
	withi Som	Ĭ	29b. Signature and title of certified	" Xead				se number 463 46	,	29d. Date signed (M	onth, Day, Year)
•			30. Name and address of person	who completed cause of d	leath (Iten	n 23a) (Type,	Print)	\wedge	1 1	1 11 1	0
	ア) を Star	to	Huma Shak 31. Date filed (Month Day, Year)	32. Registr	25 ar's Signa	Kent	avenu	e, Cum	berlan	d, Maryl	and 21502
	Registra		31. Date filed (Month, Day, Year	1009 Seresa	J.	park				1	
_											

				eartment of Health and Me	ental Hygien	^e 2009 03101
			1. Decedent's Name (First, Middle, Last)	ertificate of Death	Reg. N	3. Time of Death
	Physicia		Conrad Raymond Graeber, Jr.	_		eay Year
Y Contract	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death
1		•	Roland Park Place	Baltimore		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 1 ★ M 2 □ F 82 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)
	Director		210-16-2980 TWM 2DF 82 Yrs.	J	Jan. 22, 1	1926 Pennsylvania
	yland now at		10a. State 10b. County 10c. City, Town or L			10d. Inside City Limits
	e Mar la-f st	ctor	MD Baltin	nore		1 X Yes 2 No
	or 28 be no	Dire	10e. Street and Number Roland Park Place	10f. Zip Code	10g. C	Citizen of What Country?
	sath v is 23a nust	era	830 West 40th Street 11 Marital Status 12 Was Decedent Ever in U.S. 13	21211 Was Decedent of Hispanic Origin? (Spec	oify Yes or No-	USA 14. Race - American Indian,
36	permit. Pages 1 and 2 should be flied within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: I fleem 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give WWII	. Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R 1 ☐ Yes 2 ▼ No Specify:	Rican, etc.)	Black, White, etc. Specify: White
215-0036	2 hour	ted	15 Decedent's Education 16a, Dec	edent's Usual Occupation	16b.	Kind of Business/Industry
215	hin 72 e. an "na Medi	ple		re kind of work done during most of working DO NOT use retired)		D
21	ed wit ygien ner tha	Completed	4 Cher	mical Engineer		Engineering
Maryland	l be fil ntal H ed oth	Be	17. Father's Name (First, Middle, Last) Conrad Raymond Graeber, Sr.	18. Mother's Name (en Surname)
- Z	thould nd Me mark matic	욘		ling Address (Street and Number or Rural		y or Town, State, Zip Code)
Ma	nd 2 salth ar alth ar 27 Is r trau		G 15 G 1 TTT/	2 North Charles Stre		imore, MD 21212
Jre,	es 1 a of Hea litern		20a. Method of Disposition 20b. Place of Disposition 20b. Place of Disposition	position (Name of ematory or other place) Jan.	ate 20c.	Location - City or Town, State
Ē	Page nent cant ant: If ury o			rematory, INC. 20	109 Ba	altimore, MD
Baltimore,	permit. Departimport. any inj		21. Signature of Funeral Service Licensia	22. Name and Address of Facility Barranco & Sons, P.A 195 Gov. Ritchie Hwy	. Severna , Severna	Park Funeral Home Park, MD 21146
			23a ntl. Inter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or	r respiratory arrest,	Approximate Interval Between Onset and Death
3	Physician		Immediate cause (Final disease recondition re-ming in death)	sons disEl	ASE	Onset and Death
	/Medical Examiner		Due to (or as a consequence of):			
	1 66	-	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
	outed id ansit	Examiner	Cause. Enter Underlying Cause (Disease or Injury that initiated events C.			
ó,	icate be executed physician and s the burial-transit	Exa	resulting in death) Last Due to (or as a consequence of):			
68760,	ohysic the bi	dical	d			
		/Me	IF FEMALE: 23c. If yes, outcome pf pregnancy			23d. Date of delivery
Вох	requires that the death certil een signed by the attending rould be detached for use a	Completed by Physician/Me	in the past 12 months? 4 Pregnant at time of death	B Ectopic pregnancy D Other (specify)		Month Day Year
P.O.	t the c by the	hys	9 Unknown			
S, F	w requires that the de been signed by the should be detached	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	4	o use contribute to the cause of death?
ord	requir een si nould	ted	Supranucteur paisy		1 ☐ Yes	2 No 3 Probably 4 Unknown
3ec	aw Isb	nple			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
alF	ate Pag				1□ Yes 21001	
Ĭ,	Physician: r this certificatal director, I	o Be	25. Was case referred to medical examiner? 1 Yes 2 Hospital: 1 Inpatient 2 ER/Outpatient	26. Place of Death		6 □Other (Specify)
0	ding Phys 1. After this funeral di	n: To	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at 2	28d. Describe how in	
ior	Attending F r death. ector: After by the funer	atlo	2 ☐ Accident investigation	M 1 Yes 2 No		
Division or Vital Records,	al or Atte after der I Directo d in by th	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, building, etc. (Specify)	street, factory, office 2	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.			
	To the within 2 To the comple	Me	1	29c. License number	29d. l	Date signed (Month, Day, Year)
	110		Miany (In mi)	D35102	JA	NUARY 15, 2009
5	Medi	þ	30. Name and address of person who completed cause of death (Item 23a) (Typ	e, Print) IN CHAVITS STYRE	t BAHI	more maryland
	St: Reaist	ate rar	31. Date filed (Monte, Pay, Year) 32. Registrar's Signature	hard 1	(

DHMH 17 Rev 1/2001

Certificate of Death

4b. City, Town, or Location of Death

2. Date of Death

2009

4c. County of Death

05:30 PM

January

Physician

1 - For State Registrar

1. Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

RITA

GILLELAND

Anne Arundel Spa Creek Center Annapolis If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 9. Birthplace (State or Foreign Country)
Washington, D.C. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 11/30/1933 1 □ M 2 □ F 577-48-5228 75 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Extra in er must be notified at once. 1 □Yes 2 No Director Maryland Queen Anne's Chester 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21619 United States 302 Teal Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 2 Specify: 3 M Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nuclear Power Artist/Draftperson 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John A. Ward Gertrude Grasse ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John T. Gilleland/Son 610 Edwards Road, Annapolis, Maryland 21409 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1-16-2009 Edgewater, Maryland 4 □ Donation 5 □ Other (Specify) Kalas Crematory 21. Signatura of Fungial Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home Males 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final ASPIRATION PNEUMONIA DAY disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as e consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ ADENO CARCINO MA 1 ☐ Yes 2 No 3 Probably 4 Unknown PANCREAS Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 2.X No 1 ☐Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral D time certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of 2009 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of 2001 Medical Parkway, Annagolis Registrar

			State of Maryland / Department of Health 1 - For State Registrar Certificate of Death	n and Me h		ene g. No. 2009	03103
ı	Physicia /Medic		1. Decedent's Name (First, Middle, Last) ATRICIA A A GAUG	2	2. Date of Death Month	Day Year-	3. Time of Death
1	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location 1146 Old Davidsonville Rd. Davidsonvill	.1e		4c. County of Dear	
ı	Funeral Director		5. Social Security Number 6. Sex 1. Age (In yrs. last birthday) 1. Under 1. Year 1. If	s Min	3. Date of Birth (Month, Day,) 0/6/1940	rear) Co	hplace (State or Foreign untry) r land
	Aaryland f show	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Anne Arundel Davidsonville				10d. Inside City Limits 1 □Yes 2 ☒ No
	ith the l	Director	10e. Street and Number 10f. Zip Code		100	g. Citizen of What Co	untry?
	eath w	Funeral	1146 01d Davidsonville Road 21035 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Or	Origin? (Speci	ifv Yes or No-	USA 14. Race - Ame	rican Indian.
036	urs after d al", or iten	þ	11. Marital Status 1 Never Married 1 N		can, etc.)	Black, White	e, etc.
Baltimore, Maryland 21215-0036	be filed within 72 hours after death with the Maryland Ital Hygiene. od other than "natural", or items 23a or 28a-f show event, in Predicel Explicat must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most life. DO NOT use retired)	ost of working	'	6b. Kind of Business/	
2	filed w Hygie other ti ent, th	Be Co	12 Clerk 17. Father's Name (<i>First, Middle, Last</i>) 18. Moth	ther's Name (First, Middle, Ma	JS Postal aiden Surname)	Service
ylan	should be fand Mental se marked of sumatic ever	To B	1 1 1			Gertz	
Mar	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic ev once.		19a. Informant's Name/Relationship (Type. Print) Paul Donald Gaug/Husband 1146 Old Davidsonv				
ore,	les 1 ar of Hea if item		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Dat		c. Location - City or	·
<u><u>E</u></u>	iit. Pages artment of ortant: If its injury or o		4 Donation 5 Other (Specify) Lakemont Mem. Gardens 21. Signature Funeral Service Licensee 22. Name and Address of Facil				
Ba	permit. Departr Importz any inji		f. (alas) 2973 Solomons I		-		
	Physician	8 1	23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	as cardiac or	respiratory arres	st,	Approximate Interval Between Onserland Death
	/Medical Examiner		Due to (or as a consequence of):				
-	ed	iner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury				
Ď,	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or Injury that initiated events resulting in death) Last C				
8760	cate ohys the	dical	d				
O. Box 6	death certif e attending id for use as	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 poinths? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ □ Unknown			23d. Date of de Month	ivery Day Year
rds, P	requires that the peen signed by th nould be detache	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part	rt I.		cco use contribute to	the cause of death?
	The larate has	Completed			24a. Was an autopsy performe	prior to	topsy findings available completion of cause of
VItal	siclan: certific irector,	Be	examiner/ .		Check only one)		
n 0	ng Phy fter this neral di	on: To	1 ☐ Yes 2 ☐ No		Bd. Describe how injury occurred		
DIVISION	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		of. Location (Stre City or Town,	et and Number or Ru State)	ural Route Number,
		edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date a 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, de and manner stated.	and place, and place, and place, and	nd due to the cau d at the time, dat	use(s) and manner a e and place, and due	s stated. to the cause(s)
	To t with To t	×	29b. Signature and title of certifier 29c. License number DV/9	438	296	Date signed (Mont	1, Day, Year) 1 19 2009
	1060		Marine and address of berson who/completed cause of death (Item 23a) (Type, Print) DEFENSE	176	HWAY	HNNAP	MPLIFUS
	Sta Registr		JAN 2 0 2009 January B. January D.		/		

n d	For State	Se Type or Pring State of Ma	aryland /	Depar	tment of I	Health and N	/lental H	lygier	ne2 () (09	03104
sician	1. Decedent's Name (First, Middle	Last) Cliff	ord Ge			er, Jr	2. Date of [Month			Year	3. Time of Death
edical	4a. Facility Name (If not institution,	give street and number)	3 6 0		h City Town o	or Location of Death	01		12	07	1926 M
miner	Anne Arundel Me		_		Annapol			١.	4c. County o		. 1
ral		6. Sex 7. Age	e (In yrs. last bi	irthday)	f Under 1 Year	If Under 24 Hrs.	8. Date of E		inne A	9. Birthpla	ace (State or Foreign
r	110-30-4827 Usual Residence of Decedent	1 Д М 2□F	69	Yrs.	Months Days	Hours Min.	July 4			New Y	ry)
'n	10a. State 10b. County		10c. City, Tow		ion					10	d. Inside City Limits
Director	Maryland Anne	Arundel	Croft	on	10f. Zip Code	-		1 10 1			1X□Yes 2□No
		2			21114			USA	Citizen of Wh	nat Count	ry?
Funeral	11. Marital Status	12. Was Decedent E	Ever in U.S.	13. Wa	s Decedent of H	Hispanic Origin? (Sp	ecify Yes or N		14. Race	- America	n Indian
by Fu		Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates;	lo		es, specify Cub Yes 2 ∑ No	an, Mexican, Puerto Specify:	Rican, etc.)		Black, Specify:	White, et	c.
led	15. Decedent's		16a	a. Deceder	t's Usual Occup	nation		16b	Kind of Busi		ite
plet	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or 5-		(Give kin	d of work done NOT use retired	during most of work	ing	MA	artme		,
Completed		5+		gisti	cs Engi	neer			ted St		
Be	17. Father's Name (First, Middle, L	,				18. Mother's Name		le, Maide	en Surname)		
0	Clifford George					Catherin					
	19a. Informant's Name/Relationshi					and Number or Run				tate, Zip (Code)
	Janice M. Geige: 20a. Method of Disposition		20b. Place o	of Disposition	n (Name of	ace Croft	on, MD		14 Location - Ci	ity or Tow	n. State
	1 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	Removal from State	cemete	ery, ciemati a k emo:	ory`or other plac	ce)				-	
	21. Signature of Funeral Service L		Memori	ial G. 22. N	ardens ame and Addre	ss of Facility Rob	/2009 ert E.	<u> Dav</u> Eva	<u>idsonv</u> ns Fur	<u>zille</u> peral	Home
	PI-F-FY	in				apolis Ro					. Home
	23a. Part 1. Enter the disease, or c shock, or heart failure. List or	omplications that caused have one cause and each line	the death. Do	not enter t	ne mode of dyir	ng, such as cardiac o	or respiratory	arrest,		4	Approximate nterval Between
	Immediate Cause (Final disease or condition	_a. Resp	inato	MF	alun	, oew	h			Ċ	Onset and Death
	resulting in death)	Due to (or as a	consequence	of)							- y
er	Sequentially list conditions,	b Due to (or as a	consequence	Wen	mon	ia _					1) Ays
Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ad	enve	arı	wina	lene	MAL	de l	's SME		Minths.
_	resulting in death) Last	C. Due to (or as a	consequence	of):				7	J July	00	Annow - n
Ca		d									
ME	IF FEMALE:	23c. If yes, outcome o	of pregnancy								
Pnysician/Medical	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 4 Pregnant at	☑ Fetal death		topic pregnancy	у		İ	23d. Date of Month	,	ay Year
2	1 □ Yes 2 □ No 9 □ Unknown	9 ☐ Unknown	o or death	3 LI ()[nei (apecity)						
<u> </u>	Part II. Other significant condition	s contributing to death but	not resulting in	n the under	lying cause give	en in Part I.	23e. Did	tobacco	use contribu	ute to the	cause of death?
3							<u> </u> 122	Yes 2	2 □ No 3[☐ Probab	oly 4 🗆 Unknown
combiered							24a. Was		24b. We	re autops	y findings available
5							auto perfe 1 □ Yes	psy ormed? 2 No	dea	or to comp th? IYes 2	letion of cause of
2	25. Was case referred to medical examiner?	Hospitali				26. Place of Death					
	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatien 28a. Date of Injury	t 2 ER/Ou			4 L Nursing Hor				(Specify)	
2	1 Natural 5 Pending 2 Accident investigat	(Month, Day,		Time of njury	28c. Injury Work U 1 □\	/at ?? Yes 2 □No	8d. Describe	how inju	iry occurred		
IIICa	3 ☐ Suicide 6 ☐ Could not	be 28e. Place of Injury	y - At home, far				8f. Location /	Street a	nd Number	or Rural F	Poute Number,
Certification: To	4 ☐ Homicide determine	building, etc.	(Specify)	,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or To	wn, State	e)	iuiai N	outo railibei,
ealcal	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best of aminer: On the basis of and manner state	examination an	e, death oc id/or invest	curred at the tim gation, in my op	ne, date and place, a pinion, death occurre	and due to the	cause(s date an	s) and mann id place, and	er as <i>s</i> tat I due to th	ed. e cause(s)
ME	29b Signature and title of certifier	Sid mailler state	1		29c. License	number		29d. Da	ate signed (A	Month, Da	y, Year)
)	John Ull	1 del	Man	1	D	21438		90	nua	ry 1:	3,2009
	MICHAEL J. Le	PENTA W	1441	Type, Print	ENSE	HGHW	my A	NN/	rous	MO	Mey
	31. Date filed (Month, Day, Year) JAN 15 2	32. Registrar	's Signature	han							
	0.111 202	- Latreen	p.	years	i the						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland 89600 the Health and Mental Hygiene 2009 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician /Medical Month Year Carrett January 1719 PM Xavier 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 634826104 Months Days Hours ω **Director** 07-03 2002 CXAS Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Anne Arundel 1 Yes 2 No Funeral Director Severn MD10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country ō r items 23a or ner must be r Statesman United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after Examiner 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Ö 1 Yes 2 No If Yes, Give Year or Dates: Specify þ Specify: Black 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education ed other than "natu event, the Medical (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Elementar tudent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental 27 is marked or traumatic ever Garrett ant ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) State Mother MD 1849 21144 LISA Grant Severn 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State t = 10 Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. Meadowridge Mem. PK 02-07-09 Elkridge Donation 5 Other (Specify) 21. Signa 22. Name and Address of Facility Daugnerty Family Funeral Home 2401 Mountain Road Pasadena, MD 21122 23a. Part 1. Enter the disease, of complications that caus shock, or heart failure. List only one cause on each Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final Stroke **Physician** 3 days disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Intracranial bleed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Vascular Abnormality or Attending Physician: The law requires that the death certificate be executed physician and is the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 🗌 No 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 \square Nursing Home 2 No 1 Inpatient မ 1 🗌 Yes 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Watural 5 Pending investigation Injury after death. 1 🗌 Yes 2 🗌 No Accident the Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

To the Funeral D Hospital Example 1 Example 1 Example 2 | 1 Example 2 | 1 Example 3 | 2 Example 3 | 1 Example 4 | 2 Example 4 | 2 Example 5 | 2 Example 6 | 2 Example 6 | 2 Example 6 | 2 Example 7 Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (check only and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) RES 000 01-22-2009

DHMH 17 Rev 1/2001

State

Registrar

600 North Wolfe St, Baltimore, MD, 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Yang

31. Date filed (Month, Day, Year)

FFR 0 4 2009

Dr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 01 **Physician** 0^{Ye ar} 26 2145 Glover Allen James J۲. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ALLEGANY WMHS-BRADDOCK CAMPUS CUMBERLAND If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Yes Jan 15, Birthplace (State or Foreign Country)
____ 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 5. 1<u>943</u> MD 214-42-0164 Director 66 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, Ite Medical Evaminar must be notified at any injury or other traumatic event, Ite Medical Evaminar must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Allegany Cumberland Director 1 □ ¥es 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14705 McGill Drive 21502 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 □Yes 2 □ **N**o If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 □ N Specify <u>გ</u> 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2+ Kelly Springfield Tire Director of Data Processing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gladys Arlena Glover James Allen Glover, Sr. 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wife 14705 McGill Drive Cumberland MD 21502 Peggy Glover 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State Restlawn Memorial Gardens 1/31/2009 MD LaVale 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA 21. Signature of Furieral Service License 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate vause (Final disease or andition resulting in death) **Physician** YCATLS /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician; The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) the 9 Hlnknown 9 Unknown signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 | Yes 2 | 1 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 1 No Be 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐ Yes 2 NO 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation of the safer death.

Funeral Director: A letely filled in by the further further for the further furth 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated 29b. Signature and title 29d. Date signed (Month, Day, Year)

within 2

DHMH 17 Rev 1/2001

Registrar

30. Name and add

31. Date filed (Month Day,

R. and GIZCETON PRINE CUMBERLANDINI

son who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Henig January 12 2009 Seymour /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Andrus House Bethesda Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7 Age (In vrs. last birthday) Birthplace (State or Foreign Country) 6 Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1X M 2 □ F Director 90 April 15,1918 153-16-1881 New Jersey Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, Ite Medical Exardirect must be recitived at 1 XYes 2 No Directo Maryland | Montgomery Kensington 10e. Street and Number 10g. Citizen of What Country? 20895 3926 Denfeld Court United States of America Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Tyes 2 No
If Yes, Give
Year or Dates: 1945-46 1 Never Married 2 Married Baltimore, Maryland 21215-0036 <u>_</u> 1 ☐ Yes 2 ☐ No Specify: Caucasian 3 V Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mechanical Engineer U. S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be David Henig Edith Guidamach ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leslie P. Henig - Son P.O. Box 530, Garrett Park, MD 20896 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 15 ☐ Other (Specify) Lincoln Crematory 1/22/2009 Brentwood, Maryland 22. Name and Address of Facility Simple Tribute Funeral & Cremation 21. Signature of Fulleral Pervice Licensee 1040 Rockville Pike, Rockville, MD 20852 23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Caude Final disease or condition resulting in death) Approximate Interval Between Onset and Death omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ply one cause on each line. **Physician** Aspiration Pneumonia 2 weeks /Medical Due to (or as a consequence of): Examiner Dysphagia 2 weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examlner Due to (or as a consequence of): y physician and is the burial-trans Advanced Age resulting in death) Last Due to (or as a consequence of): Physician/Medical Vascular Disease use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 → Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 □Yes 1 ☐Yes 2 ☐ No 2 🙀 No

12:45 p_M

Year

i or Attending Physician: The law requires that the death certificate be executed after death. Box 68760, P.O. Division of Vital Records,

cate has been signed by the a page 2 should be detached certificate After Director: within 24 hours a To the Funeral C To the Hospital

Be

Certification: To

Medical

25. Was case referred to medical examiner?

Hospital:

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 Pending investigation

6 Could not be

28a. Date of Injury (Month, Day, Year)

and manner stated

1 Yes 2 No

27. Manner of Death 1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

State

MD Loreto S. Albiol, 8218 Wisconsin Ave #305 Bethesda, MD 20814 Ragistrar's Signature 2009 20

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

26. Place of Death (Check only one)

Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D31319

1 ☐ Yes

2 No

Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Group Home

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

January 13, 2009

28d. Describe how injury occurred

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death HOLZER 8:00 A.M **Physician** January 195, 2009 Myrna /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Montgomery Rockville 11513 Cushman Rd. 8. Date of Birth 9. Birthplace (State or Foreign March 28,1941 El Tzabeth, NJ If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Social Security Numbe Hours 138-32-6644 1 □ M 2 🗶 F Months Days Min. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show ir than "natural", or items 23a or 28a-f shov New York 1X Yes 2 No Director New York 10e. Street and Number 10f. Zip Code 10022 10g. Citizen of What Country? 333 East 54th St., Apt. 4B U.S.A Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. White 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 🕅 No If Yes, Give Year or Dates Specify þ Specify. 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event, the Mental Injury or other traumatic event, the Mental Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Exxon/ Mobil 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Block Maxine Holzer 2 Herbert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11513 Cushman Rd., Rockville, MD 20852 19a. Informant's Name/Relationship (Type. Print) Patricia Goldstein / sister 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State B'nai Israel Cemetery Jan. 18,2009 Elizabeth, NJ 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 21. Signature of Funeral Service Licensee, 254 Carroll St., NW, Washington, DC 20012 Trubal 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2 months Immediate Cause (Final disease or condition resulting in death) Lung Cancer, Metastatic **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and for use as the burlal-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 ☐ Pregnant at time of death 5 Other (specify) P.0. certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 XYes 2 No 3 Probably 4 Unknown <u> Diabetes Mellitis</u> Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Tes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, p. 25. Was case referred to medical Be 26. Place of Death (Check only one) 's residence Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 ☐ Yes 2 ☐ XIo 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number January 15, 2009 D63940

Registrar

State

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a), (Type Print) Hospital, 1650 Orleans St., Rm 209, Donald W. Parsons, MD, Phd Johns Hopkins Hospital, 1650 Orleans St., Rm 209,

Baltimore, MD 21231

M.D., PH.D

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Ma	aryland		artment o			lental Hy	0	000	0210	10
	Physicia	an	1. Decedent's Name (First, Middle, Last				imoato	Dean	,	2. Date of De Month	Day	Year	3. Time of Death	M
	/Medic Examin		Cynthia Hardenber 4a. Facility Name (If not institution, give	street and number)			4b. City, Tow		of Death	Januar	4c. Cou	inty of Death	5:45 P	
-que	Funeral Director		Casey House Montg 5. Social Security Number 6. Se 124-46-2648 1			ast birthday) Yrs.	Rockv If Under 1 Ye Months Da	ar If Unde	r 24 Hrs. Min.	8. Date of Bir (Month, Da June 1	th ay, Year)	Coun	ace (State or Fore	ign
	be filed within 72 hours after death with the Maryland trail Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Majical Examiner must be notified at	al Director	Usual Residence of Decedent 10a. State Virginia 10b. County Fairfax 10e. Street and Number 13096 Park Crescen		,	, Town or Lo						of What Coun		
215-0036	2 hours after deat natural", or items	ted by Funeral	11. Marital Status 1 The Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edit (Specify only highest grace)	12. Was Decedent E Armed Forces? 1 Yes 2 IN If Yes, Give Year or Dates:		16a. Dece	Was Decedent If Yes, specify C I □ Yes 2 ☑ Ident's Usual Ochiend of work de	No Specify	<i>/</i> :		Spe	Race - Americ Black, White, e ecify: Whi f Business/Inc	te.	
21	iled within 7 Hygiene. ther than "r nt, it e Man	Completed	Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	College (1-4or 5	+)		kind of work do DO NOT use re	ager		(First, Middle	A.O.			
Maryland	e	To Be	William Richard Ha 19a. Informant's Name/Relationship (7)			19b. Mailir	ng Address (Str	Jo	an Ma	rasco			Code)	
Ġ,	1 and Health tem 27		Tamara H. Gabriell 20a. Method of Disposition				Reserve sition (Name o matory or other			rive, I		lle, MD on - City or To		
Baltimore,	permit. Pages Department of Important: If it any injury or o		1 Burial 2 Cremation 3 4 Donation 5 Other (Specify, 21. Signature of Funeral Service Licens)		ropol:	Ltan Cro	ematory Idress of Faci	y 20 ^{lity} D e V	09 01 Fune	eral Ho			
	Physician		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final	ne cause on each lin	ne.	. Do not ent	er the mode of	dying, such a				sburg,	MD. 2087 Approximate Interval Between Onset and Death	
	/Medical Examiner	Examiner	disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	a. Metasta Due to (or as a B. Seizure Due to (or as a	a consequ e Dis	ence of): order	Cance	r						
3760,	certificate be executed rding physician and ise as the burial-transit	lical Exa	that initiated events resulting in death) Last	Due to (or as a	a consequ	ence of):								
O. Box 68	certifik ding p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 🗌 Fetal	death 3	☐ Ectopic pregr ☐ Other (specif					Date of delive Month	ry Day Year	
rds, P.	quires that t en signed by uld be deta	þ	Part II. Other significant conditions co	ontributing to death bu	ut not resu	lting in the u	nderlying cause	given in Part	l.				e cause of death? ably 4 🔼 Unknow	
al Reco	s ician: The law re s certificate has bee lirector, page 2 shoi	Completed								24a. Was auto perfo 1 □ Yes	psy ormed?	prior to cor death?	osy findings availal npletion of cause o	ble of
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Directors After this certificate has been signed by the attent or the Funeral Directors. After this certificate has been signed by the attence of the funeral director, page 2 should be detached for use the funeral director, page 2 should be detached for user.	tion: To Be	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	Hospital: 1 Inpatie 28a. Date of Inju (Month, Da)	ry	ER/Outpatier 28b. Time o Injury	f 28c.	Other	lursing Ho	h (Check only one 5 ☐ Res 28d. Describe	idence 6 🛚		Hospice	
Divisi	al or Atten s after deat il Director: ed in by the	Certification: To	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc.	ury - At ho c. (Specify	me, farm, str					Street and Nu wn, State)	umber or Rura	l Route Number,	
	the Hospit iin 24 hour the Funera ppletely fille	Medical ((Check only 2 Medical Exam	ysician: To the best iner: On the basis o and manner sta	f examinat		ivestigation, in	my opinion, de	eath occur		date and pla	ce, and due to	the cause(s)	
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	,		30. Name and address of person who of Jocelyne Kouatche 31. Date filed (Month, Day, Year)		001 M	uncast		Road	Rock	ville,	MD 208	55		
	Sta Registi		JAN 2 1 2009		-		all .							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2009 Physician 1:13 Hoellich January Jakob /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Lothian 6108 Fishers Station Road If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours Months 1 M 2 □ F Romania 02-01-1926 82 220-32-6191 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10h County 10a. State ir than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 No Director Lothian Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20711 6108 Fishers Station Road by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☑ Married Hygiene. other than "natural", or i 1 ☐ Yes 2 🕅 No Baltimore, Maryland 21215-0036 Specify: If Yes, Give white 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) construction carpenter permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 Is marked other i any injury or other traumatic event, It 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hach Teresa Hollich Franz ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Crownsville, MD 21032 670 Old Herald Harbor Road, Rosalie Mallonee, daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 1/21/2009 Alexandria, VA 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licensee William 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Obst 50086 4 years **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. led by the attending physician detached for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be det ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 2 □No certificate 2 **2** No 1 ☐ Yes 1 □ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? director. Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death After 5 Pending investigation Injury 14 Natural 1 □ Yes 2 □ No 2 Accident

Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death

To the Funeral Director:
completely filled in by the

6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

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2009

State Registrar

Medical

29b. Signature and title of certifie

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31. Date filed (Month, Day, Year) JAN 2 1 2009 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

134

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie U 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month Louise Hout Kathleen 17, 2009 11:55 January 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Allegany Allegany Co. Nursing and Rehab Ctr. Cumberland If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Months Days 1 ☐ M 2 🖫 F Yrs. 96 02/14/1912 Maryland 220-10-8828 Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10b. County 10a, State 1 Yes 2 □ No Cumberland MD Allegany 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21502 USA 412 Warwick Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☐ No 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White If Yes, Give Year or Dates: 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Financial Secretary Church 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Robinette Mary Gertrude Wilson Ernest Scott 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10400 Hinkle Road, SE, Cumberland, MD George Robinette / Nephew Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Greenmount Cemetery | 01/20/2009 Cumberland, MD * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, P.A. of Funeral Şeryice LiCensee 404 Decatur Street, Cumberland, MD Part 1. Emfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1 Immediate Cause (Final AND CHRONIC FAILURE ACUTE CONGESTIVE HEART disease or condition resulting in death) Due to (or as a consequence of) CARDIOMYOPATHY SCHEMIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

/Medical **Examiner** The law requires that the death certificate be executed Box 68760, P.0. Division of Vital Records.

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Physician

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Certification

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29a. Certifier

(Check only one)

29b. Signature and title of certifier

Funeral

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filed within 72 hours after death within 4 Hygiene.

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permit. Pages 1 and 2 should be file Department of Heath and Mental Hy Important: If Itam 27 is marked othe any injury or other traumails avena

Physician

Baltimore, Maryland 21215-0036

with the Maryland

State Registrar Robustiano J. Barrera, M.D., 211 2009

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29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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MD 500 Memorial Avenue, Cumberland, Service Stanature farks

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Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Eventine to use the notified at once.		19a. Informant's Na Harold		ship <i>(Type. Prin</i> e / Hu:			1	-	-			al Route Number Cumber				502	
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	one) 29b. Signature and	HE DECATING	an-	d manner:	stated.		1	29c. Licen	se number	,		29d. D.	ate signed	(Month,	Day, Year)	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2009 JANUARY 19 11:40 AM MARY A. HENSON /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CECIL UNION HOSPITAL ELKTON 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Min. Months Days Hours 1 □ M 2 💢 F 216-20-1280 87 Director MARCH 4, 1921 MARYLAND Usual Residence of Decedent 10d Inside City Limits 10a. State 10b, County 10c. City, Town or Location 28a-f show 福 injury or other traumatic event, the Mudical Examinar must be notified 1 Nes 2 No CHESAPEAKE CITY Director MARYLAND CECIL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 21915 USA 348 CAYOTS CORNER ROAD items 23a Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black White etc within 72 hours after 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore. Maryland 21215-0036 ō 1 ☐ Yes 2 🔀 No Specify: Specify: BLACK þ 3 X Widowed 4 □ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event Elementary/Secondary (0-12) College (1-4or 5+) PRODUCTION WORKER FOOD 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WALTER GIBBS EDITH OWENS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT HENSON, JR. / SON KNICKERBOCKER DRIVE, NEWARK, DELAWARE 19713 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State BOHEMIA MANOR CEM. 01/24/09 CHESAPEAKE CITY, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility LISA SCOTT FUNERAL HOME, P.A. 552 LEWIS STREET, HAVRE DE GRACE, MD 21078 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ndome /Medical Due to ur as a consequence of): Examiner bSIS orgue many list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician: The law requires that the death certificate be executed Exami nemia and burial-tran Due to (or as a consequence of) attending physician for use as the burlal O. Box 68760 Physician/Medical the } as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) n signed by the a ld be detached for I ☐ Yes 2 No 9 Unknown 9 Unknown Δ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performe After this certificate 2 No 2 No 1 ☐ Yes 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No 1 🔲 Inpatient 2X ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ours after death.

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filled in by the fu 2 Accident investigation death. 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide e Funeral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely i (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif 29c. License number ed cause of death (Item 23a) (Type, Print) 30. Name and address of perso who comple ridge St. Elkton, MD 2192 5 Muhammed 4az 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 22 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number **Examiner** Park Anne Arundel Household Of Angels Severna 9. Birthplace (State or Foreign Country) √est Virginia 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 X F 95 Director 232-12-8539 16,19/3 West Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Anne Arundel Annapolis Maryland | 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23a 624 Sean Drive 21401 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📈 No White þ 3 ₩ Widowed 4 □ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other traumatic event, If a Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker At Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked other any injury or other traumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Barnett Catherine Baneard Jividen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Fran Nystrom/Daughter 624 Sean Drive Annapolis, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cunningham Mem. Park 1/27/2009 St. Albans, West Virginia 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signatur of Funeral Service Licensee Al. M 2973 Solomons Island Rd. Edgewater, MD. 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CEREBRO VASCULAR ACCIDENT Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed and burial-tran Due to (or Division of Vital Records, P.O. Box 68760. hed by the attending physician detached for use as the buria Physician/Medical the as IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Fetal reach

1 Live brand at time of death for use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) 9 Unknowň signed by t I be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Special Hospital: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA ဥ After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? I or Attending Patter death. 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐Yes 2 ☐No 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title

State Registrar

3/00 LORD BALTIMOREDR. HILO BALTIMORE MJ 21244 KAYNOLD Registrar's Signature 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend#19b per FH State of Maryland / Department of Health and Mental Hygiene? [] [] 9 State
Registrar AACO HEALTH DEPT. 1/20/09 CMH Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1857 HERZ16 **Physician** VIRIA /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Year) Months Days Hours Min. 1 □ M 2 Ø F 139-32-8041 89 Sept. Italy 8 1919 Director Usual Residence of Decedent 10c City Town or Location 10d. Inside City Limits 10a. State 10b. County show at 7 is marked other than "natural", or items 23a or 28a-f sh traumatic event, it sall salled Examiner must be notified Morres 2 □ No Director Maryland Anne Arundel Park Severna 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21146 41 West McKinsey Rd USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify. Specify: White à 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) 12th School Teacher 4 yrs Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be finand Mental Finand Mental Finand Mental Finand Mental Finand Fin Be Joseph Castiglia Chiara Abbrescia ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 08833 07838 New Jersey 1 and 2 s Health a permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr. Kenneth Olsen (Executor) 33 Philhower Rd. Lebanon 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Pecuest Union Cemetery 4 □ Donation 5 □ Other (Specify) Great Meadows, N.J. 22. Name and Address of Facility 821 West St. Annapolis, Md. 21. Signature of Funeral Service Licensee Javy 12, Base MCE18 21401 Wm. Reese & Sons Mortuary, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opeet and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner as Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine lon the burial-transi and that initiated event resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 pronths? Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy perform certificate 1 □Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 ☑ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1/1 Inpatient ၉ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated.

Box 68760, The law requires that the death certificate be P.O. of Vital Records, Division

Maryland 21215-0036

Saltimore,

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) 32. Registra

Name and address of person who completed cause of death (Item 23a) (Type, Print)

100

Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 0420 01 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 2/18/1926 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex Months Days Hours Min. 1 M 2 F 209-28-6424 82 Germany Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 □Yes XX No Anne Arundel Annapolis 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2700 South Haven Rd. 21401 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ∐Yes Solva If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2√√No Specify Specify: White 3 Novidowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4+ Owner Operator Kennel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Martha Gabriel

5862 Deale Churchton Rd.

20b. Place of Disposition (Name of cemetery, crematory or other place)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Deale, MD 20751

20c. Location - City or Town, State

Physician * /Medical Examiner

Physician

/Medical

Examiner

Director

by Funeral

Completed

Be ပ MD

11. Marital Status

19a. Informant's Name/Relationship (Type. Print)

Robert Haller

Signature and title of oprtifier

20a. Method of Disposition

Funeral

Director

Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exercitive could be notified at once.

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

Medical Certification: To Be Completed by Physician/Medical Examine

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlat-transit

Division of Vital Records, P.O. Box 68760,

1 ☐ Burial 2 ☐ € Cremation 3 ☐	Removal from State	cemetery, crematory or of	her place)		•	
4 □ Donation 5 □ Other (Specify		lantic Crema	tory 1/1	14/2009 G1	en Burnie	e, MD
21. Signature of Funeral Salicen	see	22. Name an		ardesty Fun		
17/2 / Ch			gely Ave.	Annapolis,		•
23a. Part : Enter the disease, or company shock, or heart failure. List only	olications that caused the de one cause on each line.	A		A	5.70	Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Wpira	non prie	undria	, Japan	10k	Weeker
	Due t vor es a cons	equence of):	menti	•		year
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	equence of):				
that initiated events ' ' resulting in death) Last	Due to (or as a cons	equence of):				
	d					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pre- 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3 D Ectopic p			23d. Date of de Month	elivery Day Year
Part II. Other significant conditions of	ontributing to death but not i	resulting in the underlying ca	ause given in Part I.			to the cause of death? Probably 4 ☑ Onknown
				24a. Was an autopsy performed	d? death?	utopsy findings available completion of cause of s 2 \(\sum \) No
25. Was case referred to medical examiner?			T	Death (Check only one)	73.11%	MERCE
1 Yes 2 No	Hospital: 1. Inpatient 2	☐ ER/Outpatient 3 ☐ DC	A Other: 4 - Nursing	g Home 5 ☐ Residenc	e 6 ⊡Other (Sp	ecify)
27. Manner of Death Natural 5 Pending 2 Accident investigation		28b. Time of lnjury M	8c. Injury at Work? 1 ∐Yes 2 ☐ No	28d. Describe how		
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury · A building, etc. (Spe	t home, farm, street, factory ecify)	office	28f. Location (Stree City or Town, S		Rural Route Number,
	sysicien: To the best of my liner: On the basis of exam					

State Registrar DEFENSE

and manner stated

MM 32. Registrar's Signature

npleted cause of death (Item 23a) (Type, Print)

amend #5 PERFH G889 3/12/09 Jh State of Maryland / Department of Health and Mental Hygiene Certificate of Death

1 - State Registrar

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** January 19, 2009 5:20 P M Joseph Jack Ingram /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number 2025 If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months 1⊠M 2□F Yrs. 88 **Director** 460-10-2825 May 30, Texas 1920 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Injury or other traumatic event, the Medical Examiner a ust be notified at 1X Yes 2 ☐ No Director Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 211 Russell Avenue #73 20877 United States Funeral Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status 1 TYes 2 No 1942-Black, White, etc. Armed Forces 10 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ Specify: **Black** 3 ☐ Widowed 4 ☐ Divorced Year or Dates: than "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) n and Mental Hygiene. 5+ Mathematical Statistician Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Izora Williams ပ Gideon Holstein Ingram 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health ar 211 Russell Avenue #73 Gaithersburg, MD. 20877 Blanche L. Ingram (Wife) 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Important: If It any Injury or c 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenlawn Mem. Park Groves, Texas 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licensee 10 East Deer Park Drive Gaithersburg, MD. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Metastatic Melanoma /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of) Box 68760, attending physician Physician/Medical yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ ficate has been si, r, page 2 should b 1 ☐ Yes 2 🔼 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Division of Vital 1 □ Yes 2 No 1 ☐ Yes 2 □No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2K No Certification: To 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending within 24 hours are. To the Funeral Director: Af investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature of title of certifier, 29c. License number 29d. Date signed (Month, Day, Year) D0061937 10+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , 1500 FOREST GLENRD, SILVER SPRING, NO CANDACE L. WILSON 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month

Exami **Funeral** Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I've Madical Evaminer must be notified at once. Baltimore, Maryland 21215-0036

Samuel Johnson

1 - For State Registrar

Physician

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlat-transit 3

ian cal	Samuel Algie Johnson	2		ay Year 3 2009	3. Time of Death C
ner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Loc Easton Memorial Hospital Easton			c. County of Death	,,,,,
	5. Social Security Number 6. Sex, 7. Age (In yrs. last birthday) If Under 1 Year I			9. Birth	place (State or Foreig
	220-28-1179 1 M 2 F 76 Yrs. Months Days H. Usual Residence of Decedent	Hours Min. 1	3. Date of Birth (Month, Day, Year 2-31-19	32 Mar	yland
	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limit
ctor	Md. Dorchester Hurlock				1 □Yes 2 N
Dire	10e. Street and Number 10f. Zip Code 6530 Glen Oak Hotel Road 21643		"	Citizen of What Cou	ntry?
Funeral Director	6530 GIen Oak Hotel Road 21643 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispar			USA 14. Race - Ameri	oon Indian
Fur	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married		can, etc.)	Black, White,	etc.
d by		Specify:		Specify: Bla	
Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired)		16b. I	Kind of Business/Ir	dustry
Com	Elementary/Secondary (0-12) College (1-4or 5+) 12 College (1-4or 5+) Bus Contractor	or/Driv	er Bi	us conti	ractor
Be			First, Middle, Maide.		
2	Monroe Slyvester Johnson Ra 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and I			olley	. 0. 4.)
	Courtney Johnson / Wife 6530 Glen Oa				
	20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date		ocation - City or To	
	4 Donation 5 Other (Specify) Md. Veterans Cem.	01-21	-09 Hi	urlock,	Maryland
	21. Signature of Funeral Pervice License 22. Name and Address of	f Facility Ben	nie Smit	th Funer	cal Home
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, su			,Md.2164	Approximate
	shock, or heart failure. List only one cause on each line.			4	Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence) f): Builder Carer putting and the properties of the proper		v		Clary
I Examiner	Sequentially list conditions, in any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence or).		7		Months
dica	d				
ıysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □			23d. Date of delive	ery Day Y ear
by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	Part I.	23e. Did tobacco	use contribute to the	he cause of death?
ed b	Hypertersion		1 ☐ Yes 2	No 3 Prot	oably 4 ☐ Unknown
Completed	Chronic Ciche disease		24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of
			performed? 1 ☐ Yes 2 ☐ No	death?	2 No
Be	Hospital:	. Place of Death (C			
n: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		5 Residence		(y)
atio	1 St Natural 5 Pending (Month, Day, Year) Injury Work? 2 Accident Investigation M 1 Yes	_	•	,	
Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f	Location (Street as City or Town, State		al Route Number,
Medical Co	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time,	date and place, and on, death occurred	d due to the cause(s at the time, date an	s) and manner as s id place, and due to	stated. o the cause(s)
Me	29b. Signature and title of certifier 29c. License num	mber		ate signed (Month,	
	1/ de 1./ Mit s 6400	43	Jor	may 13,	2009
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PAUL W. Monte 219 S. Woshington F.	EASTM		2/601	
te	31. Date filed (Month, Pay, Year) 22. Registrar's Signature	-/10()/	1		
ar	JAN + D 2003 Keeping A. Back				

Regist DHMH 17 Rev 1/2001 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumafte event, the Medical Examiner must be notified at any Injury or other traumafte event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Physicia /Medic Examin

b

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit Division or Vital Records, P.O. Box 68760,

1	For State Registrar		State o	f Maryland		artment of rtificate o			1ental H		ne 2 0	09	0311
ian	1. Decedent's Name (Fi		ast) Yung Ku	Kau					2. Date of I Month Janu		Day 18, 2	Year 009	3. Time of Death
cal ner	4a. Facility Name (If not					4b. City, Town	or Location	n of Death			4c. County		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	Forest Gl	en Nur	sing & 1	Rehab		Si	lver	Sprin	ıg			Monte	gomery
	5. Social Security Numb	1	Sex 1 □ M 2 X F	7. Age (In yrs. la 95	ast birthday) Yrs.	Months Day			8. Date of I (Month, June	Day, Ye	1913	Cour	place (State or Fore htry) Korea
1 F	Usual Residence of Dec 10a. State 10t	b. County		10c. City	Town or Lo	ocation						Ti	0d. Inside City Lim
_			ma tru			c	ilwan	. Spri	NO.				1 Yes 2 🕱
- A	Maryland 10e. Street and Number	Montgo	mety			10f. Zip Code		Spu	Jig	10g.	Citizen of \	What Cour	ntrv?
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Funeral	11. Marital Status	oc nve	12. Was Dec	edent Ever in U.S	3. 13.	 Was Decedent o If Yes, specify Cı			ecify Yes or	No-		e - Americ	an Indian,
by Fur	1 ☐ Never Married 3 🕱 Widowed 4 ☐		Armed Fo 1 ☐ Yes If Yes, Gi Year or D	2 X No ve		if Yes, specify Cl 1 ☐ Yes 2 🎛 N			Hican, etc.)		Specify	ck, White,	etc. Asian
Be Completed		Decedent's E	Education rade completed)		(Give	dent's Usual Occ kind of work dor DO NOT use reti	e durina m	ost of work	ing	168	o. Kind of B	usiness/In	
dmo	Elementary/Secondar	ry (0-12)	College (1-4or 5+)	me.	Homen	-/					Own t	lome
O	17. Father's Name (Firs	t, Middle, Las	st)				18. Mot	ther's Nam	e (First, Midd	lle, Mai	den Surnan	ne)	
10 B	Muuna	Jun K	im						Do My	ınq	Kim		
	19a. Informant's Name				19b. Maili	ng Address (Stre	et and Num	nber or Rur	al Route Nur	nber, C	ity or Town,	State, Zip	Code)
	Chunghwa T.	Kay-D	aughter	-in-law	9608	Falls B	ridge	Lane	, Pote	mac	, MD	2085	4
	20a. Method of Disposit 1	remation 3		State	metery, cre	osition (Name of matory or other p	i		Date		C. Location -		
	21. Signature of Funera			Noze	2		lress of Fac	cility Hir	ies-Rij	ralo	li Fun	eral	aryland Home, Iv 1g, MD209
lical Examiner	Immediate Cause (Fina disease or condition resulting in death) Sequentially list condition if any, leading to immediate, leading to immediate cause. Enter Underlyin Cause (Disease or injurthat initiated events resulting in death) Last	ons,	b	Al Zhei (or as a consequ (or as a consequ (or as a consequ	ence of): ence of):	S 1)/is	ease						Onset and Death
Physician/Med	IF FEMALE: 23b. Was decedent pre in the past 12 mor 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		1 ☐ Live	tcome pf pregnar birth 2 □ Fetal nant at time of de lown	death 3[⊒Ectopic pregnai ⊒Other <i>(specify)</i>				-		te of delive	ery Day Year
þ	Part II. Other significan			eath but not resu			given in Par	rt 1.			co use cont		ne cause of death
Completed	Fail	une	to the	pive	1 114	sperter	5,0	en	24a. W	as an itopsy		Were auto prior to co death?	psy findings availa mpletion of cause
ပို	25. Was case referred	to medical					ne Dia	non of Deat	1 Yes	-/	(No	1 ∐ Yes	2□ No
m	examiner?		Hospital: 1 🗆	Inpatient 2 ☐ E	ER/Outnatie	nt 3 DOA			h <i>(Check onl</i> ome 5□Re		e 6 🗆 🗠	per (Specif	iv)
tion: To	27. Manner of Death 1 Natural 5	☐ Pending investigation	28a. Date (Mor		28b. Time o Injury	f 28c. In			28d. Describ				<i>y</i> /
Certification:	2 Accident 3 Suicide 6 4 Homicide	Could not determine	be 28e. Place	e of injury - At hor ling, etc. (Specify	me, farm, st				28f. Location City or			er or Rura	al Route Number,
edical (aminer: On the b	e best of my know pasis of examinat oner stated.									
Me	29b. Signature and title	- A	s dly				nse numbe			29d.	Date signe	d (Month,	Day, Year)
	30. Name and address NURUL CH	of person who	o completed cau	D; 152	16 DI.	Print) NO DR/	<u> </u>		TON			•	
ate	31. Date filed (Month, L	Day, Year)	∌ 32. F	Registrar's Signat	ure								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Funeral Director Pages 1 and 2 should be filed within 72 hours after death Baltimore, Maryland 21215-0036 Health and Mental Hygiene.

the Medical Examiner must be notified at

"natural", or

permit. Pages 1 and 2 s Department of Health a Important: If Item 27 is any Injury or other trau 21. Signature Funeral Service Licensee Immediate Cause (Final disease or condition resulting in death) Breast **Physician** cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) P.O. s been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ Be Completed **Division of Vital** director. 25. Was case referred to medical 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) funeral 27. Manper of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident s after death 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide determined 4 Homicide within 24 hours after
To the Funeral Dire
completely filled in b 29a. Certifie Medical (Check only one) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) JAN 16 2009 Registrar's Signature State Registrar DHMH 17 Rev 1/2001

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 842 AM Physician laryanna 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Mandrin Chesapeake Hospice House Harwood If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 8/27/1944 Months Days Hours Min 1 □ M 2 🖬 F Pennsÿlvania 171-36-2628 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☑ No Funeral Directo Maryland | Anne Arundel Edgewater 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21037 3553 Oak Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐ No If Yes, Give A Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 🕅 No Specify by Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker At Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fontanesi Elizabeth White ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James N. Kline, III/Husband <u>3553 Oak Drive Edgewater,MD.</u> 21037 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lakemont Mem. Gardens 1/19/2009 Davidsonville, MD. 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD. 21037 23a. Part 1. Enjor the disease, or complications to a caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death month 23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 **X**No 1 ☐ Yes 1 Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Qther (Specify) NOSONCE 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) Quo Bestyte Rd Suke 300 Annapolis MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar		,	Cer	tificate of	Death	Re	g. No. 20	09	03	122
	Physicia	an	1. Decedent's Name (First, Middle, Las						2. Date of Death Month	Day	Year	3. Time of	
	/Medic		Wilma		ing	-	th Oits Tassa	al and a of Darth	January	Day 18, 200		5:04A	М
	Examin	er	4a. Facility Name (If not institution, give Country Home	e street and number)			Harwood	r Location of Death		Anne A:		e1	
	Funeral		5. Social Security Number 6. S		(In yrs. last	t birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min,	8. Date of Birth (Month, Day,			place (State or	r Foreign
	Director		200-20-4300	□ M 2🌠 F 77		Yrs.	monare Days	Trodio IIIIII	Aug. 30,	1931	Ohio		
	aryland show		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	Town or Loc	ation				1	0d. Inside Cit	y Limits
	Mary a-f sh	ctor	Maryland Anne Ar	undel	David	lsonvi	11e					1 □Yes	2 ∑ No
	or 28	Dire	10e. Street and Number				10f. Zip Code		10	g. Citizen of Wi	nat Cour	ntry?	
	s 23a	Funeral Director	1361 Double Gate	Road	Constant C	10.14	210		asifu Van av No	USA	A en oui	can Indian.	
_	fter de r item	Fun	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🕅 N		1		lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Black	, White,	etc.	
3	72 hours after death with the Maryland Inatural", or items 23a or 28a-f show Jical Exa cliver must be coefficed at	d by	3 ☐ Widowed 4 🖾 Divorced	If Yes, Give Year or Dates:		1	∐Yes 2∐iNo	Specify:		Specify:	Whit	:e	
1215-0036	be filed within 72 hours after death with the Maryla hal Hyglen and 28 a c 28 a c 28 a febov dother than "natural", or items 23 a or 28 a febov event, the Marieal Exemination in the beneathed.	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	1	16a. Deced	ent's Usual Occup	oation during most of work d)	ing	6b. Kind of Bus	iness/In	dustry	
71	within iene. than "	dmo	Elementary/Secondary (0-12)	College (1-4or 5-	+) .	Barte		u)	I	Hospita	litv		
andz	e filed all Hygis other vent, II	Be C	17. Father's Name (First, Middle, Last)					18. Mother's Name					
<u> a</u>	2 should be fi and Mental H is marked ot raumatic ever	To E	William Ba	iley				Haze1	Boggie	es			
Mar	2 sho n and is ma rauma		19a. Informant's Name/Relationship (•	and Number or Rur		· -			
ص ف	1 and 2 Health a em 27 is		Brenda I. King/Da 20a. Method of Disposition	ughter			sition (Name of latory or other place	ate Road		ville,M Oc. Location - C			
ב ב	Pages ent of nt: If it		1 ☐ Burial 2 🕅 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify				atory`or other plac ematory		/2009 E	daeusto	∽ M	arvlan	a
saltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic evonce.		21. Signature 1 Funeral Service Licen			22.	Name and Addre	ess of Facility Ge	orge P. I	Calas Fr	iner	al Home	5
מ	e in in in	7 8	A. F. Ka	clasfi		2	973 So1o	mons Isla	nd Rd. Ed	dgewate	r,MD	.21037	
			23a. Part 1 Enter the disease, or comp shock, or heart failure. List only	plications that caused one cause on each lin	e				or respiratory arre	st,		Approximate Interval Betw Onset and D	veen
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a TARK			SDIS	EASE			1	NKN	OWN
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Ď,	icate be executed physician and the burial-transit		resulting in additive Edec	Due to (or as a	a consequen	ice oi):							
08/00	certificate be executed ding physician and ise as the burial-transit	Medical		. d									
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ם	e deal	Physician/	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4 ☐ Pregnant at 9 ☐ Unknown			Other (specify) _	·,		Mont	.h	Day Y	ear
7.	that the		Part II. Other significant conditions o	ontributing to death bu	t not resultin	ng in the un	derlying cause giv	en in Part I.	23e. Did toba	acco use contrib	oute to the	ne cause of de	eath?
ďs,	uires n sign ld be	d b	DEMENT	TA					1 ☐ Yes	s 2 No 3	∃ □ Prot	ably 4 □ U	nknown
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ř	The la ate ha	E O							autopsy perform 1 🗆 Yes 2	ed? de	eath? □Yes	mpletion of ca 2 □ No	use of
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10	Physi this c	2	1 ☐ Yes 2 🕅 No 27. Manner of Death	Hospital: 1 Inpatie	nt 2 ER	l/Outpatient	28c. Inju	er: 4 Nursing Ho	me 5 Resider		r (Specif	X) -/0//	
0	th. : After	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	(Year)	Injury	Wor		200. Describe not	Tinjuny Goodinos	•		
UNISION	Atter ector by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju	ry - At home	e, farm, stre	et, factory, office		28f. Location (Stre	eet and Number State)	r or Rure	l Route Numb	per,
5	ital or irs afte ral Dir lled in		1 4	V.								· · · · · · · · · · · · · · · · · · ·	, L
	Hosp 24 hou Funel	edical	29a. Certifier (Check only one) Check only one) Certifying Ph Certifying Ph Check only one)	ysician: To the best on niner: On the basis of and magner sta	examination	edge, death n and/or inv	occurred at the ti estigation, in my	me, date and place, opinion, death occur	and due to the ca red at the time, da	use(s) and man te and place, ar	ner as s	tated. the cause(s)	
	To the Hospital or Attending Physician: The law requires that the death ce within 24 hours after death. To the Luneral Director: After this certificate has been signed by the attendi completely filled in by the funeral director, page 2 should be detached for use	Mec	29b. Signature and title of certifier	distribution sta			29c. Licens	se number	29	d. Date signed	(Mogth,	Day, Year)	
	. > - 0		1 anchria	Thom	note.	1(R)	IA RI	07995		1/18/	120	19	
	4		30. Name and address of person who			, , , , ,	,		/				
	160		Andrea J. Ostrande 31. Date filed (Month, Day, Year)	er, CRNP 70			Drive Su	ite G Lir	thicum H	leights,	MD.	21090	
	Sta Registr		JAN 2 0 2009	OZ. Hegistia	a signature	1							

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 7.15 PM **Physician** 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Media 76. If Under 1 Year | If Under 24 Hrs. 5. Social Security 6. Sex 7. Age (In yrs. last birthday Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Min. 1 □ M 2 🕻 F Hours Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d, Inside City Limits 28a-f show Injury or other traumatic event, the Mudical Examiner must be notified at 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or and 2 should be filed within 72 hours after death with USA 21 marle Funeral "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces Black, White, etc. 1 □Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No <u>≽</u> Specify: Specify: 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiem 27 is marked other Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kollias ္ရ anes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ko mother 760 , m /10 colton permit. Pages 1 a Department of Hes Important: If item any Injury or othe once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 1/20/09 Glen Burnie MD 21. Signature of Europeral Service Lice see 22. Name and Address of Facility 21401 Hardesty Funeral Home P.A. 12 Ridgely Ave Ann. MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Ihr disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Day Year Pregnant at time of death 5 Other (specify) g | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed?
1 □Yes 2 ☒No 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 💢 Inpatient Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural Injury 5 Pending 2 Accident investigation 1 ☐ Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical 2001 Eindfleisch 2anne DiOi

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State State Registrar AMEND#1, perMD, 1/20/09, DPS, MoCo Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) M.Corine Lucchesi 2. Date of Death Day Year **Physician** Jan 0006 M 12 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and nymber) **Examiner** Y099 50 10 5 toomer Nol UPY 9 Birthplace (State on Foreign Country)
Mississippi 5. Social Security Number If Under 1 Year If Under 24/Hrs. 7. Age (la yrs. last birthday, Date of Birth (Month, Day 6. Sex **Funeral** 1 □ M 2 □ F Days Hours Min June30 427-26-9845 86 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, If a Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Silver Spring 1 ☐ Yes 2 XNo Maryland Montgomery Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20904 3122 Gracefield Road, #CT421 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify. White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+ Administrative Supervisor Dept. of Defense 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry Arthur Chatham Minnie Boles ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any Injury or other trau Maurice P. Lucchesi -husband 3122 Gracefield Rd., #CT421 Silver Spring, Md. 20904 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 1/15/2009 Mt. Olivet Cemeterv Washington, D.C. 4 □ Donation 5 □ Other (Specify) Donald V. Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, 21. Signature of Funeral Service Licensee 0 Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) mE **Physician** YOCAY /Medical Due to (or a a consequence of) **Examiner** Sequentially list conditions, if any localing to it models cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, 2 Physician/Medical attending p for use as 1 ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (specify) □Yes 2⊠No signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant oonditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was *a*n page 2 s autopsy performed certificate 2 No 1 ☐ Yes 2 ☑ No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1⊠Yes 2□No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28b. Time of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Fel/ trains n 24 hours after death. Ie Funeral Director; Aft bletely filled in by the fun 10 217 1103 M 1 ☐ Yes 2 ☑ No 28f. Location (Street an Number or Rural Route Number, Recipion or Town, State) 3122 5 00 000 20904 10 2009 2 Accident 300 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 4 one 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 240 35 12/00 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SMACHADO ROAV GRALEFIELD 31/0 SILVER SPRING (L) 31. Date filed (Month, Day,

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State	of Marylar	nd / Depa <i>Cei</i>	artment of F rtificate of	lealth a Death	and M	ental Hyg R	iene _{eg. No.} 200	19	03125)
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	spita nours neral		29a. Certifier Certifyi	ng Physician: To t	he best of my kn	owledge, deat	h occurred at the ti	me, date an	id place, a	and due to the o	ause(s) and man	ner as s	stated.	_
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	(Check only 2 Medical one)	Examiner: On the	basis of examination	ation and/or in	vestigation, in my	opinion, deat	th occurre	ed at the time, d	ate and place, ar	d due to	the cause(s)	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene $2\,0\,0\,9$ 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Irving Ralph LIPSKY January 20, 2009 8:05 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. July 15, 1917 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □X M 2 □ F Washington, DC 91 <u>577-22-9463</u> Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 No Silver Spring Maryland Montgomery 10g. Citizen of What Country? United States 20906 3005 S. Leisure World Blvd., #415 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: WW II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married white 1 ☐ Yes 2 ☐ No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manager Educational Aids 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Louis Lipsky Ida Bishow 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 3005 S. Leisure World Blvd., #415, Silver Spring, MD 19a. Informant's Name/Relationship (Type. Print) Florence Lipsky, Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Lebanon Cemetery 01/22/09 Adelphi, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Lio Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ongestive Heart disease or condition resulting in death) FAILUIZ yers Due to (or as a consequence of): DIONANY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events southing in death). YEARS resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performe 1 □ Yes 2 🗷 № 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 | Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

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Physician

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permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any Injury or other traunonce.

Baltimore, Maryland 21215-0036

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Physician/Medical

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director After this funeral

Division of Vital Records, Medical Certification: To or Attending To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Aft completely filled in by the fun 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 07966 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maple Avenue Takoma 7901 nen Registrar's Signature

Registrar

31. Date filed (Month, Day, Year) 21

09-00410 Joo Hyung Lee

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death . Decedent's Name (First, Middle,Last) Physician/ Month Day January 14, 2009 1620 hrs Lee Hyoung **Medical Examiner** Joo c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Montgomery Bethesda Suburban Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 24Hrs. If Under 1 Year 7 Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Country) S.Korea Months Davs Hours Sept.10,1925 214-11-3661 83 Director 1 X M 2 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a, State an y 0b. County Rockville 1 X Yes 2 Montgomery MD 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho ar other traumatic event, the <u>Medical Examiner must be maifited</u> at annual to a second that the traumatic event, the Medical Examiner must be maifited at a content traumatic event, the Medical Examiner must be maifited at a content traumatic event, the Medical Examiner must be maifited at a content traumatic event, the Medical Examiner must be maifited at a content traumatic event, the Medical Examiner must be maifited at a content traumatic event, the Medical Examiner must be maifited at a content traumatic event, the Medical Examiner must be maifited at a content traumatic event. Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number USA Apt. 608 20850 95 Dawson Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. Armed Forces White etc. Never Married 2 X Married Yes Asian Yes 2 X No specify: Specify: Yes. Give Yea Widowed 4 Divorced à 16a. Decedent's Usual Occupation (Give kind of work done 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Seoul Bank Baltimore, MD 21215-0036 Banker 4 18.Mother's Name (First, Middle, Maiden Surname)

Jung-Il Park 17. Father's Name (First, Middle, Last) Sang-In Lee Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 312 Stone Springs Lane Middletown, Md21769 Jae Young Lee/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a, Method of Disposition crematory or other place) 2 X Cremation Removal from State Burial 1/19/2009 Beltsville, Md Chesapeake Crem. Important: Donation 5 Other Apecify: injury or PHTLTF D. RTNALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd. Silver Spring, Md2091 f Funeral Se /ice Licenses 21. Signat Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line /Medical Death a, Blunt Force Trauma of the Chest and Abdomen Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical physician a UNPENDED AMENDED the Hospital or Attending Physician: The law requires that the death certificate be him 24 hours after death. Records, P.O. Box 68760, 23d. Date of delivery 23c. If ves, outcome of pregnancy IF FEMALE 23b. Was decedent pregnant in the Day Year 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Yes 2 V No 3 Probably 4 Completed 24h Were autopsy findings available 24a. Was ar prior to completion of cause of autopsy certificate has performed? death? Yes 2 1 🗸 Yes No 26 Place of Death (Check only one) After this certifi 25. Was case referred to medical Division of Vital Be Hospital: 1 Residence 6 V Other: Scene ER/Outpatient 3 DOA Nursing Home 5 Inpatient 1 V Yes 28a. Date of Injury (Month Day Year) Jan 14, 2009 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death Driver auto fixed object collision Certification: 1536 hrs Natural Yes 2 V No Pending Director: 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide or Town, State) SB Viers Mill Road at Broodwood Road, Rockville, MD determined (Specify) Major Road / Highway Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the] within and manner stated 0 ٥ 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier January 15, 2009 O.C.M.E. completed cause of eath (Item 23a) 30. Name and address of person with 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Russell Alexander MD.

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31. Date filed (Month,

2. Registrar's Signature

OCME

OCASE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month RANK C. MUDIHICUM 07.00 PM VIAL 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Howard County General Hospital Columbia Howard If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day,) July 30, Birthplace (State or Foreign Country) MD 5. Social Security Number 6. Sex 1 **2** M 2 ☐ F Age (In yrs. last birthday) Days Hours Year) 1930 Months Min 78 213 34 2031 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore Gwynn Oak 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 United States 1227 Stamford Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Xyes 2 No If Yes, Give Year or Dates: 1947–52 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Salesman Sales 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Linthicum Helen unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Clara Linthicum/Wife 1227 Stamford Rd. Baltimore, MD 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Park: 1-24-2009 Elkridge, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. Signature of Funeral Service Licensee M01044 Jum (4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) espiratory Volume Sequentially list conditions, if any, leading to infine triate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). TENSION Due to (or as a consequence of): ARTERY DIZEASE IF FEMALE: 23c. if yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Renal Discose 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a, Was an autopsy eun mia 1 □ Yes 2 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 → Copatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No

Physician /Medical Examiner sician and burial-transit requires that the death certificate be executed

Box 68760,

P.0.

Division of Vital Records,

permit. Pages 1 and 2 s Department of Health a Important: If Item 27 Is any Injury or other trau once.

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

ģ

Completed

MD

7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the medical Examiner mant be notified at

2 should be filed within 72 hours after and Mental Hygiene.

Is marked other than "natural", or ite

3altimore, Maryland 21215-0036

Examiner attending physician for use as the buria Physician/Medical signed by the a \$ Completed Be

Certification: To

1 Natural 2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of

To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical (241)

Registrar

28a. Date of Injury (Month, Day, Year)

and manner stated

5 Pending investigation 6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 > Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

DESCIMAD

0062704 Swite #100

29d. Date signed (Month, Day, Year) Jan Ellscott

on who completed cause of death (Item 23a) (Type, Print) 30. Name and address of per Ridge Road

32. Registrar's Signature 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	Otato of Ma	, y	Cer	tificate of l	Death	Re	eg. No2009	03130
	Physicia	ın	Decedent's Name (First, Middle, Ruth	Last)	Lev				2. Date of Death Month Tanuary	1 ^{Day} , 2009 Year	3. Time of Death 1:33 P M
	/Medic Examin	al	4a. Facility Name (If not institution, 160 Konrad Mor		Hev	y	4b. City, Town, or Lothian	Location of Death	January	4c. County of Death	1
	Funeral Director				(In yrs. la 85	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day July 11	Year) 9. Birth Co. 1923 New	nplace (State or Foreign untry) Haven Conn.
	0		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	cation				10d. Inside City Limits
:	e Mary 3a-f sh	Director	MD Anne A	rundel	Lo	thian					1 □Yes 2√2 No
:	n with the		10e. Street and Number 160 Konrad Mor	gan Way			10f. Zip Code 20711		1	0g. Citizen of What Co	untry?
21215-0036	permit. Pages 1 and 2 should be flied within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I fleam 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the modical Evantment must be muttined at once.	by Funeral	11. Marital Status 1 ☐ Never Married ※ Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E- Armed Forces? d 1 □ Yes 2 □ No If Yes, Give Year or Dates:		'	Nas Decedent of H fYes, specify Cuba I □Yes 2√ No	lispanic Origin? (Span, Mexican, Puerto Specify:	Hican, etc.)	14. Race - Amer Black, White Specify: Wh:	, etc. ite
15-0	"natur	Completed	15. Decedent's (Specify only highest			(Give	dent's Usual Occup kind of work done DO NOT use retired	durina most of work		16b. Kind of Business/l	ndustry
212	withir jiene.	dwo	Elementary/Secondary (0-12)	College (1-4or 5+	+)		lerk			Utilitie	S
nd	be filectal Hyg	BeC	17. Father's Name (First, Middle, La	ast)				18. Mother's Nam	e (First, Middle, I	Maiden Surname) Koe:	nia
Maryland	d Men marke natic	ပ္	Max 19a, Informant's Name/Relationshi	n (Timo Print)	A1	bert	on Address (Street	Anna and Number or But	ral Route Number	r, City or Town, State, Z	
Z	nd 2 staith an alth an 27 is r		Sherman Levy	Husband			,	rgan Way		•	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Baltimore,	Pages 1 an nent of Hea nt: If item iry or othe		20a. Method of Disposition 1 ▼Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		ce	emetery, crer	sition (Name of natory or other place Veterans	1/21		20c. Location - City or Cheltenham	
Balti	permit. Departm Importa any Inju		21. Signature of Jun ra Service L				2. Name and Address ardesty I		ome P.A.	12 Ridgely	21401 V Ave Ann,MD
	Cate be executed by School Cate be executed by School Cate by Scho	Examiner	23a. Part1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a c. Due to (or as a	e. A consequence a consequence	ence of):	Ilmo,	nay		ure	Approximate Interval Between Onset and Death
P.O. Box 68760,	eath certifi attending for use as	Physician/Medical I	IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 □ Yes 2 L No 9 □ Unknown	d	2 ☐ Fetal time of de	death 3[eath 5[□ Ectopic pregnanc □ Other (specify) _			23d. Date of del Month	Day Year
rds, F	w requires that the de been signed by the should be detached	by	Part II. Other significant condition	ns contributing to death bu	nt not resu	ilting in the u	nderlying cause giv	ven in Part I.		bacco use contribute to es 2 ☐ No 3 ☐ Pi	o the cause of death?
al Records,	n; The law red ificate has bee or, page 2 shou	Completed	25. Was case referred to medical	die Ins	W	ffic	lene	CA Place of Dog	24a. Was a autops perform 1 Yes	prior to death? 2 No 1 ☐ Yes	atopsy findings available completion of cause of 2 □ No
Ž	yslcia is certi directo	o Be	examiner?	Hospital: 1 ☐ Inpatie	nt 2 🗆	ER/Outpatie	nt 3 □ DOA	ner: 4 \(\sum \) Nursing H		ence 6 ☐ Other (Spe	cify)
Division of Vital	Attending Ph sr death. ector: After th by the funeral	ation: T	27. Manner of Deat Natural 5 Pending 2 Accident investigation		ry v, Year)	28b. Time o Injury	Wo	ryat rk?]Yes 2□No	28d. Describe h	ow injury occurred	
Divis	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification: To	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determine		ry - At ho c. (Specif)	me, farm, st	reet, factory, office		28f. Location (S City or Tow	treet and Number or Ri n, State)	ural Route Number,
	e Hospite 24 hours e Funera letely fille	edical (29a, Certifier 1 Certifying (Check only one)	Physician: To the best of the basis of appd manner sta	f examina	wledge, dea tion and/or i	th occurred at the to	ime, date and place opinion, death occu	e, and due to the our	cause(s) and manner a date and place, and due	s stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and fittle of certifier	Down	PI	mo	29c. Licen	se number	181	29d. Date signed (Mont	h, Day, Year)
('	42		30. Name and address of person v	np, MO1	a LM	Q Ctr	#302	, Walde	ONFINO		
	Sta Regist	ate	31. Date filed (Month, Day, Year)	32. Registra	ar's Signa	ture	lan He			200	002

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** ,2009 LIAN JANUARY 19 7:10A SIANG /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 1 M M 2 □ F 7. Age (In yrs, last birthday) **Funeral** Months Days Hours Min 56 586-47-1639 January 10,1953 Burma **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show ying injury or other traumatic event, the Wedical Evertines must be retified at ane. 1**X**Yes 2 □ No Frederick Director Maryland Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Burma 21703 514 Sugarbush Circle Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status filed within 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify Asian þ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. nt: If item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Animal Technician Research 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thang Tin Tlem No Zam ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1028 Chinaberry Dr., Frederick, MD 21702 / Cousin Thang H. Lyan 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 1/24/2009 Frederick, Maryland 4 □ Donation 5 □ Other (Specify) Resthaven Memorial 21. Signatu Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, of complications that caused the treath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure (List only one cause on each line.) Approximate Interval Between Onset and Death Imme lale Cause (Final disease or condition resulting in death) **Physician** Years irrhosis /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and bunal-tran physician Physician/Medical attending physic for use as the b IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) □Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown anemia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 Al No 25. W ase referred to medical examiner? 2 No 1 ☐ Yes 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 💢 DOA 1∐ Yes Certification: To 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

after death.

Director: After this certificate has been signed by the and in by the funeral director, page 2 should be detached

n 24 hou.⊾ the Funeral Dire npletely within 2

State Registrar

Medical

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

6 ☐ Could not be

determined

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

eemo Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lee solarex 610

31. Date filed (Month, Day, Year)

2 Accident

3 Suicide

29a, Certifier

4 Homicide

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 2009^{ear} Jan. 30, 4:00 A Geraldine Evelyn Lewis 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Cumberland Allegany Golden Living Center If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Months 1 □ M 2 🕇 F Hours Maryland 215-12-2266 Dec. 5, 87 1921 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 □Yes 🋂 □ No Allegany LaVale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 U. S. A. 888 Weires Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 21 No Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Welcome_Hostess Dairy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth (Wade) Plummer

Approximate Interval Between Onset and Death

Day

29d. Date signed (Month, Day, Year)

30,2009

Year

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show Iry or other traumatic event, the Medical Examiner must be notified at permit. Page Department o Important: If any Injury or

Maryland 21215-0036

Baltimore,

P.O. Box 68760,

or Vital Records,

Division Hospital or Attending

death.

within 24 hours after death
To the Funeral Director:
completely filled in by the

Physician

/Medical

Examiner

10a. State

MD

Director

Completed by Funeral

Be

2

Examiner

Physician/Medical

Completed by

Be

Certification: To

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifie

Poona1 31. Date filed (Month, Day, Year)

FFR 0 4 2009

Funeral

Director

Physician /Medical Examiner

requires that the death certificate be executed the burial-trar physician signed by the should page 2 s certificate Physician: this

Charles H. Plummer III 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter 888 Weires Avenue, LaVale, MD Linda C. Reuschlein 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State MSVC at Rocky Gap Feb. 3, 09 Flintstone, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Hafer Funeral Service, P.A. 21. Signature of Funeral Service License Orang 1302 National Hwy., LaVale, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 4thense lente Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 | Yes 2 | No 3 | Probably 4 | Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1∐ Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

State Registrar

DHMH 17 Rev 1/2001

Seton Dr.

and mariner stated

924

Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D003676

Ste. 2, Cumberland, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2009 9:37 p M January Claude Malebranche /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 8. Date of Birth (Month, Day, Yea March 28, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs. **Funeral** Days Year) Months Hours Min. **X**|X M 2 □ F 1934 Haiti 220-47-5087 74 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show 10a State 10b. County traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director 28a-f Maryland Montgomery Kensington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with ò 20895 Haiti 23a 3209 University Blvd., West, #22 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ∐Yes 2 TNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Black Specify Specify: ģ 3 ☐ Widowed 4 ☐ Divorced 'natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) 5+ Medical Pharmacist permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 is marked other I any injury or other traumatic event, III 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Amelie Dartiquenave Jules Malebranche ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3209 University Blvd. W., #22, Kensington, MD 20895 Marie Claude Malebranche/Wife Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 16, Jan. Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2009 Alexandria, Virginia 21. Signature of Funeral Service Lio 22. Name and Address of Facility Francis J. Collins Funeral Home Inc 500 University Blvd. W. Silver Spr - Dales MichaedZ Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Acute a. Sepsis /Medical Due to (or as a consequence of): Examiner Chronic Prostate Cancer Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed Due to (or as a consequence of): burial-Box 68760, physician Physician/Medical the attending IF FEMALE: for use a 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No P.0. 9 Unknown 9 Unknown Š signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, ģ 2 X No 3 Probably 4 Unknown 1 Tyes Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has page 2 autopsy performed? certificate 2 👿 No 1 ☐ Yes **Division of Vital** Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this Plospital or Attending Pl 24 hours after death. Funeral Director: After the 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 🙀 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide e Funeral I 29a. Certifier 1 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2.

State Registrar

29b. Signature and title of certifier

John M. Wallmark, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signatu

29c. License number

D53177

9707 Medical Center Drive, Rockville, MD 20878

29d. Date signed (Month, Day, Year)

January 15, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar			State 0	i iviai	yland /	-	tificate of		ia mon	Reg	, No.2	009	031	34
f	Division		1. Decedent's Nam	ne (First, Middle	, Last)								ate of Death Jonth	Day	Year	3. Time of	
	Physicia /Medic	al	Joseph				sina	a					anuary		2009 unty of Deatl	7:30	P M
And the sales	Examine	er	4a. Facility Name (4b. City, Town,		Death		1	Calve		1
•			Solomon 5. Social Security N		ng C	enter	7. Age	(In yrs. last	birthday)	If Under 1 Year		Hrs. 8. [ate of Birth		9. Birt	thplace (State o	r Foreign
	Funeral Director		578-34- Usual Residence of	3461		M 2□ F		79	Yrs.	Months Days	Hours	Min. 01	Month, Day,	30	Wasi	h., D.C	•
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Exerction is ust be retilied at one.		10a. State	10b. County		<u>.</u>		10c. City, To	own or Lo							10d. Inside Cit 1 ☑ Yes	
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	or 28	Director	10e. Street and Nu	umber						10f. Zip Code			10		of What Co	untry?	
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	er de	Funeral	11. Marital Status	rried 2□ Mar		Armed Fo	orces?			Was Decedent of If Yes, specify Cu		Puerto Rica	n, etc.)		Black, White		=
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n C	Attending Physician: The Isr death. ector: After this certificate his by the funeral director, page	i.i	27. Manner of De 1 Natural	5 Pend		28a. Dat (Mo	te of Inju onth, Da		28b. Time Injury		njury at Vork? □Yes 2□1		i. Describe no	ow injury (occurred		
Sio	ten for:	icat	2 ☐ Accident 3 ☐ Suicide	6 ☐ Coul		28e Plac	ce of Ini	urv - At hom	ne. farm. s				Location (St	reet and	Number or F	Rural Route Nu	mber,
Division of	는 를 를 드	Certification: T	4 Homicide	e deter	mined	buil	lding, et	c. (Specify)	,	street, factory, office			City or Towl	n, State)			
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by		29a. Certifier (Check only	1 ☑ Certify	ing Phy	ner: On the	basis o	of examination	ledge, de	ath occurred at th	e time, date ar ny opinion, dea	nd place, and ath occurred	d due to the d at the time, d	ause(s) a late and p	ind manner place, and di	as stated. ue to the cause	(s)
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,			30. Name and a	ddress of norse	n who c	moleted ca	V/)	death (Item	23a) (Tvn	e, Print) 1	7/15	5 ///		JAM	USAN	01/0	4007
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 009 Year Jamin 18. 8:03 A M **Physician** Ruth Anne Mills /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Calvert Prince Frederick 680 Patuxent Reach Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Numbe 7. Age (In yrs. last birthday) **Funeral** Days Min 1 ☐ M 2 🔯 F 47 Washington, DC May 8, 1961 Director 212-82-9608 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene.

The state of the stat 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examiner must be notified at 1 ☐ Yes 2X No Director Calvert Prince Frederick MD 10g. Citizen of What Country? 10e. Street and Number USA 20678 680 Patuxent Reach Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married White Baltimore, Maryland 21215-0036 1 ☐Yes 2 XNo Specify. Specify: \$ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home h and Mental Hygier 7 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be be f Shirley Ruth Bradley Reuben Augustus Bogley, III မှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20678 19a. Informant's Name/Relationship (Type. Print) Health a 680 Patuxent Reach Road Prince Frederick, MD permit. Pages 1 and Department of Health Important: If item 27 any injury or other troonce. Charles N. Mills, III (husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Jan 21 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Trinity Mem. Gardens Waldorf, MD 4 ☐ Donation 5 ☐ Other (Specify) 2009 22. Name and Address of Facility Lee Funeral Home Calvert, PA 21. Signature of Funeral Service Licensee gary J. 20736 8125 Southern Maryland Blvd. Owings, MD Gøff Approximate Interval Between Onset and Death 23a. Part 1/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician TASTA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dusito (or as a consequence of). law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of) Box 68760. Physician/Medical use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year for 4 Pregnant at time of death 5 Other (specify) signed by the a Ö σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 9 No No 3 Probably 4 Unknown icate has been sig r, page 2 should b 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 1 □Yes 2 No 1 ☐Yes 2 ☐ No Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After t To the Hospital or Attending I within 24 hours after death.

To the Funeral Director, After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation filled in by the 3 Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide t 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8426 W001) COUPTA ILLI) 31. Date filed (Month, Day, Year) 32. Registra's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 For State Registrar Certificate of Death WCHD #1,per phys., 1/23/09,BA 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 3: 35 AM 21 Eleanor Eugenia Messer Eugenia Eleanor Messer 01 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, **Examiner** Salisbury Min. Wiconico The Lake Hospice QT (In vrs. last birthday) 96 Birthplace (State or Foreign Country) If Under 1 Year 7. Age 8. Date of Birth 5. Social Security Number **Funeral** 5/22/1912 Months Days 1 □ M 2 1 F 170-22-9695 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or litems 23a or 28a-f show any injury or other traumatic event, it is the control or other traumatic event. 1 ☐ Yes 2X No Director Berlin MD Worcester 10f. Zip Code 10g, Citizen of What Country? 10e, Street and Number 1 Meadow St., Apt 314 21811 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Saltimore, Maryland 21215-0036 Specify Specify: White by 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) House Keeper House Cleaning 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sara Yerger Charles Moyer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1405 N. Chase St., Ocean Pines, MD 21811 Ann <u>Lutz</u> / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 1/21/2009 Frankford, DE 4 ☐ Donation 5 ☐ Other (Specify) Cape Henlopen Crem. 22. Name and Address of Facility Burbage Funeral Home 21. Signatur of Funeral Service Lick 108 William St., Berlin, MD 21811 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTATIC **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to forme a consequence of Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 ☐ Yes 2 No 1 □Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? funeral director, 1 Yes 2 No Other: 4 Nursing Home 5 Residence of Other (Specify) Hospica Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28d. Describe how injury occurred 27. Manner of eath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? After t Natural 5 Pending investigation ours after death.
neral Director: Af 1 □Yes 2 □ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. соmpletely (Check only within 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of 00058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) QU BUX 1733 SAUS Brung up 21802 BA 10 6 Hungy 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

PARELLA .

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		1	For State Registrar	State of	Marylan				lealth and D <i>eath</i>	Mental H		2009	03137
Phys		1	1. Decedent's Name <i>(First, Middle, La</i> Rozella	st)	К.	-	M	lorti	more	2. Date of I Month	eath Da	2th Year	3. Time of Death
/Me Exan	dica nine		4a. Facility Name (If not institution, giv			nter	4b. City	Town, or	Location of Dea			County of Death	<u> </u>
Funer Direct			5. Social Security Number 6. 5	Sex 7	7. Age (In yrs. I	last birthday) Yrs.	/ /	Days	If Under 24 Hr Hours Mir		Birth Day Year)	9. Birth Cor Bedf	place (State or Foreign intry) ord Co. PA
pu >		- 1	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	ocation						10d. Inside City Limits
Marylan a-f show		2013	MD Anne Art	ınde1	Arr	nold							1 □Yes 2□No
with the	Č		10e. Street and Number 961 Arundel Driv	7e		-		p Code 21012			-	itizen of What Cou USA	intry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It. Mighal Eventual in contract.		by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Deced Armed Ford 1 Tyes 2 If Yes, Give Year or Da	ces? No X		Was Dece If Yes, sp 1 □ Yes		ispanic Origin? (In, Mexican, Pue Specify:	Specify Yes or I rto Rican, etc.)	10-	14. Race - Amer Black, White, Specify:	
vithin 72 hou sne. han "natura		Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation		16a. Dece (Give life. Booke	kind of w DO NOT	ork done d use retired	ation during most of w l)	orking		(ind of Business/II	,
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Mal ylatlu Z IZ. 12 should be filed within h and Mental Hygiene. 7 is marked other than 'traumatic event, In Mental Hygiene.		0	Lester Ro		Kc	ontz			Ruth		iah	Die	CERTIFIC TO THE PARTY OF THE PA
and 2 sh ealth and m 27 is m	9 12	1	19a. Informant's Name/Relationship (Richard Jack Mon		Son	1			ad Fork,			or Town, State, Z 051	ip Code)
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it. Pages artment of a rtant: If ite		-	4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lice)	(y)	MD	Vetera			ery 1/1 ss of Facility	.6/09	Cro	ownsvill	e,MD 21401
permit. Departi	ouce.	13	Day M	7						lome P.A	. 12	Ridgely	Ave Ann, MD
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/Medic Examin			resulting in death)	Due to (c	or as a consequ	uence of):	(col	5 20				
ad sit		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events sequents in death.)	b. Due to (c	or as a consequ	uence of):							
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To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending in completely filled in by the funeral director, page 2 should be detached for use as		Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		irth 2 ☐ Feta ant at time of c	l death 3[⊒Ectopic ⊒Other (у			23d. Date of deli Month	very Day Year
v requires that the bear signed by should be detailed.		2	Part II. Other significant conditions	contributing to de	ath but not res	ulting in the u	ınderlying	cause giv	en in Part I.			1	the cause of death?
The law recate the law recate has be good 2 sho		Completed								pe 1 □Yes	topsy rformed? 2 2 N	prior to c death?	topsy findings available ompletion of cause of
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DIVISION To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune		Certification:	2 Accident investigatio 3 Suicide 6 Could not be determined	e 28e. Place	of Injury - At hog, etc. (Specif	ome, farm, st	M reet, facto		Yes 2 □ No		(Street a own, Stat	and Number or Ru te)	ral Route Number,
Hospital 4 hours Funeral tely filled			(Check only 2 Medical Exa	miner: On the ba	sis of examina	owledge, dea ation and/or i	th occurre	ed at the ti	me, date and pla opinion, death o	ace, and due to t curred at the time	he cause(le, date ar	(s) and manner as	stated. to the cause(s)
To the within 2 To the complet		Medical	one) 29b. Signature and title of certifier	and mann	er stated.		2	9c. Licens	se number		29d. D	ate signed (Month	n, Day, Year)
				-) n	2)		3	14	8001)	01)	12/20	09,
140	0		30. Name and address of person who	completed cause	of death (Iter	n 23a) (Type,	Print)	to	1 2	() G	me (Burn	July mD
Reg	Stat	e	31. Date filed (Month, Pay, Year)	109 33 Re	egistrar's Signa	ature	to blad	,		,			

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		State Registrar				Cer	tificate of	Deatr) 	0. D. t (5	Reg. N	0.		O Time -	4 Dooth
Physicia	an	1. Decedent's Name (First, Middle	∍, Last)							2. Date of D Month	D		Year	3. Time o	
/Medic		Matilda	Meyer							<u>Janua</u>	_		.009	7:45	5 A ^M
Examin	er	4a. Facility Name (If not institution					4b. City, Town, o		of Death		4	c. County o	-	1	
		6610 Christy A	Acres Ci		(In urn In	st birthday)	Mt. A		r 24 Hrs. I	8. Date of E	Rirth	Ca	rrol.	L lace (State	or Foreian
Funeral		,	1. 3 M 2 □		84	Yrs.	Months Days		Min	July 8	Day, Yea	24	Coun	_{try)} ` Jers	
Director		146-14-4137 Usual Residence of Decedent			- 04			J		July C	, 1,	727_1	110 W	0013	
/land		10a. State 10b. County			10c. City,	Town or Loc	cation	-					10	Od. Inside C	
Many a-f sh	햣	Maryland Carr	·o11			Mt. A	iry							1 □Yes	2 ⊠ No
h the	Director	10e. Street and Number					10f. Zip Code				10g. C	itizen of W	hat Coun	try?	
h wit		6610 Christy	Acres Dr	cive			21	.771				Unit	ed S	tates	
ems ems	Funeral	11. Marital Status	12. Was I	Decedent E		. 13. V	Vas Decedent of f Yes, specify Cut	Hispanic Coan, Mexica	origin? (Spean, Puerto	ecify Yes or I Rican, etc.)	No-		Americ K, White, e		
affer affer	by Fu	1 Never Married 2 Mar	If Yes	res 2⊠N s,Give	0	1	□Yes 2፟No	Specif	y:			Specify:	. 1	White	
ural"		3 ☑ Widowed 4 ☐ Divorced		or Dates:		16a Deced	dent's Usual Occu	nation			16h	Kind of Bu	siness/Inc	lustry	
n 72 l	ete	(Specify only highe			-	(Give	kind of work done	durina mo	ost of worki	ing		71,710 01 20	5111000/1110	,	
withir ene.	Completed	Elementary/Secondary (0-12)	Colle	ge (1-4or 5-	+)		memaker	,				Ow	m Ho	me	
if ied within 72 hours after death with the Maryland filed within 72 hours after death with the Maryland Hyglene. Other than "natural", or Items 23a or 28a-f show ent, the Modical Examilmen must be notified at		17. Father's Name (First, Middle,	Last)					18. Mot	her's Name	e (First, Mida	lle, Maide	en Surname	e)		
id be ental ked o	To Be	John Mycek							Mary	Jaros	Z				
shoul Mind Mind Mind Mind Mind Mind Mind Mind	-	19a. Informant's Name/Relations	hip (Type. Print,)		19b. Mailir	ng Address (Stree	t and Num				or Town,	State, Zip	Code)	
IVIC nd 2: alth a 27 is rr trau		Barbara M. Fo	rd / Daı	ughter	:	6610	Christy	Acres	s Cir	cle M	lt. A	iry,	Mary	land :	21771
S 1 a		20a. Method of Disposition				ace of Dispo	sition (Name of natory or other pla	ace)		Date	20c.	Location -	City or To	wn, State	
Page lent ont: If		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		from State			Heaven C		Janu 22,	2009	Si	lver S	Sprin	ıg, Ma	ryland
pallilliore, Wallylallu Zizisioooo permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Modical Examination must be rediffed at once.		21. Signature of Fur eral Service		,	Jour		. Name and Addr		ility Sta	uffer	Fune	ral H	lomes	, P.A	
B a L De D		1	X De	3		8	E. Ridge	eville	e Blv	d. Mt	. Ai	ry, M	iary1	and 2	1771
		23a. Part 1. Enter the disease, shock, or heart failure. List	complications to only one cause	that caused on each lin	the death	. Do not ent	er the mode of dy	ring, such a	as cardiac	or respiratory	arrest,			Approxima Interval Be	etween
Physician		Immediate Cause (Final disease or condition				ACL	tymimens.						1	Onset and	Death
/Medical		resulting in death)	Du Du	ie to (or as											
Examiner	١.	Sequentially list conditions	b			CATEON	V-								
pi ji	i.	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	200	into (cras:		,									
recute and -trans	Examiner	that initiated events resulting in death) Last	c	ue to (or as	EMEN										
COIdS, F.O. BOX b8/60, w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	E E	,		,	a oonooqo										
phys the	hysician/Medical		d												
certific	/We	IF FEMALE:		s, outcome								, 23d. Dat	e of delive	эгу	
BOX leath cer attendin	ciar	23b. Was decedent pregnant in the past 12 months?	4 🗆	Live birth Pregnant at			☐ Ectopic pregnar ☐ Other <i>(specify)</i>				_	Мо	nth	Day	Year
the d	ysi	1 ☐ Yes 2 No 9 ☐ Unknown	9 🗆	Unknown											
s that the ned by a detact	by P	Part II. Other significant condit	ions contributing	g to death bu	ut not resu	Ilting in the u	nderlying cause g	iven in Par	rt I.	23e. Di	id tobacc	o use conti	ribute to tl	ne cause of	death?
ords, P.C. requires that the seen signed by th nould be detache										1 (Yes	2 🔲 No	3 ☐ Prot	ably 4□	Unknown
ecords law requires as been sign 2 should be	Completed									24a. W	as an	24b. \	Were auto	psy finding mpletion of	s available cause of
The I	E O									pe	rformed's 2 🔯	? 0	death? i ∐Yes		
	Be C	25. Was case referred to medica examiner?	al					26. Pla	ace of Deat	th (Check on	ly one)				
nt V hysic nis ce I direc		1 ☐ Yes 2 1 No	Hospital:			ER/Outpatie	III 3 LI DOA		Nursing Ho	ome 5 🛛 R				fy)	
VISION OT VITA Attending Physician: r death. ector: After this certific by the funeral director,	.:. -::	27. Manner of Death 1 Natural 5 □ Pendi		Date of Inju (Month, Da	ry y, Year)	28b. Time a Injury	W			28d. Describ	be how in	ijury occurr	ed		
SIO tendi eath. for: /	cati	2 Accident invest	igation					⊒Yes 2	□1/0	28f. Location	n /Ctroot	and Numb	or or Pur	al Pouto Nu	mbor
DIVISION I or Attending after death. I Director: After d in by the fune	Certification: To		mined 28e.	uilding, et	ry - At no (Specify	me, tarm, sti	reet, factory, office	•		City or	Town, St	ate)	er or mara	n noute iva	mber,
To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.		29a. Certifier	ing Physician	0 he hest	of my know	wledne deal	th occurred at the	time date	and place	and due to	the cause	e(s) and ma	anner as s	stated.	
Hos 24 ho Fun	Medical	(Check on 2 Medica	I Exa ner: On	the basis of	f examina	tion and/or in	nvestigation, in my	opinion, o	death occu	rred at the tir	ne, date	and place,	and due t	o the cause	(s)
o the ithin o the	Me	29b. Signature and title of certifi	12/1	/			29c. Lice	nse numbe	er		29d.	Date signe	d (Month,	Day, Year)	
FSFO		17	SOCK	WW.			7	5020	7			01/	21/2	20°G.	
(10)		30. Name and address of person	n who completer	suse of c	leath (Item	n 23a) (Type,				_			J.		
		Samuel P. En	g, M.D.	1502	2 S.	Main S	Street N	1t. A:	iry,	Maryla	nd 2	1771			
Sta	ate	31. Date filed (Month, Day, Year	r)	32. Registr	ar's Signa	ture	4								
Regist	rar	JAN 2	2 2000	p. red	un	13. 19	parked								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jan 28, 2009 McCabe Raymond 11:20an⁴ 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 949 Winifred Road Cumberland Allegany If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Mar 15, 1924 9. Birthplace (State or Foreign Country)

MD 7. Age (In yrs. last birthday) Months Days Hours Min 1 □ xM 2 □ F 234-26-9952 84 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Allegany Cumberland 1 ☐ ¥es 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 949 Winifred Road USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 □ No Specify: WWII Specify: 3 □ Widowed 4 □ Divorced white Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) supervisor AT&T 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Michael E. McCabe Effie Hartman McCabe 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chris McCabe 316 Schley Street nephew Cumberland MD 21502

MD

24b. Were autopsy findings available prior to completion of cause of

Physician /Medical

Physician

/Medical

Examiner

Funeral

Director

show

Director

Funeral

2

Completed

Be

2

2

within 72 hours after death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important; if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If "Medicin Examination in the profile of a

Baltimore, Maryland 21215-0036

Examiner Examine burial-tran Physician/Medical

the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician for use as the buria signed I icate has been si r, page 2 should b certificate within 24 hours after death

To the Funeral Director:
completely filled in by the

þ

Completed

Be

ဥ

Certification:

Medical

25. Was case referred to medical examiner?

2⊿No

5 Pending

investigation

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ZAMAN, M.D

FEB 0 4 2009

6 Could not be determined

1∐ Yes

27. Manner of Death

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

GAMAR

31. Date filed (Month, Day, Year)

1 Matural

Division of Vital Records, P.O. Box 68760,

20a. Method of Disposition	20b. Place of cemeter	Disposition (Name of y, crematory or other place)	Date	20c. Location - City or	r Town, State
1 □ Burial 2 □ Cremation 3 □ Removal from 9 4 □ Donation 5 □ Other (Specify)	Rocky	Gap Veterans Cem	etery 2/2/200	g Flintsto	ne ME
21. Signature of Funeral Service Licensee		22. Name and Address of Fa Scarpelli F 108 Virgini	uneral Home, PA a Avenue: Cumb	erland, MD 21502	2
23a. Frit1. Enter the diseare, or for plic tions that ca shock, or leart failure. List only one cause on ea	used the death. Do n	ot enter the mode of dying, such	as cardiac or respiratory	arrest,	Approximate Interval Between
Immediate Luse (Final disease or condition resulting in death) Due to (CURLSI or as a consequence o	J SQUAMO	VS CELL	LARCINOM	Mid 200
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	r as a consequence o	η;			
and this are in the other than the	r as a consequence o	n):			
in the past 12 months?	ome of pregnancy rth 2 Petal death ant at time of death wn	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of de Month	elivery Day Year
Part II. Other significant conditions contributing to de	ath but not resulting in	the underlying cause given in Pa		I tobacco use contribute t	to the cause of death? Probably 4 □ Unknowr

24a. Was an

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

autopsy performed? 1 □ Yes 2 □ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

SUITE 203 CUMBERLAND, MD 21502

29d. Date signed (Month, Day, Year)

JAW 30, 2009

Registrar DHMH 17 Rev 1/2001

State

10 210 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 ☐ Yes 2 ☐ No

28a. Date of Injury (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009

			State Registrar		Cer	tificate of De	eath	Reg	g. No.			
П	Physicia	an	1. Decedent's Name (First, Middle, La	_	M-D-	-11	2	2. Date of Death Month	Day Year	.	of Death	
1	/Medic		Frederick	Quay	McDon	Ald 4b. City, Town, or Lo	antion of Dooth	01-0	4c. County of De		∞AM_	
	Examin	er	4a. Facility Name (If not institution, given 128 Springdale			Cumber			Allegar			
	Funeral		5. Social Security Number 6. S	Sex 7. Age (In yrs.	last birthday)	If Under 1 Year If		B. Date of Birth			e or Foreign	
	Director		214-36-7125	¹ √x ^{M 2□ F} 69	Yrs.	Months Days	Hours Min.	Date of Birth Month, Day, Dec 21	,	irthplace (State Country) MD		
	pur w		Usual Residence of Decedent 10a, State 10b. County	10c. C	ity, Town or Loc	ation				10d. Inside	City Limits	
	f sho	ō	MD Alleg			nberland					es 2 □ No	
	28a-	rect	10e. Street and Number			10f. Zip Code		100	g. Citizen of What C	Country?		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinate to statistical at ance.	Funeral Director	128 Sprindale S	treet			21502		US.	Α		
		ıner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13. V	Vas Decedent of Hispa Yes, specify Cuban, I	anic Origin? (Speci Mexican, Puerto Ri	ify Yes or No- can, etc.)	14. Race - Am Black, Wh	nerican Indian, ite. etc.		
36	or it	y F.	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 ☐No If Yes, Give		~	Specify:		Specify:	white		
9	hour tural	Completed by	15. Decedent's E	Year or Dates:	16a. Deced	ent's Usual Occupatio	on	10	6b. Kind of Busines			
215	e. an "ne Medik	plet	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4or 5+)	life. D	kind of work done duri OO NOT use retired)	ng most of working	'		_		
2	ed with	Con	10		Secu	rity Officer		(F) 1 N. 1 (1) N. 1 (1)	Park and	Recrea	ation	
gue	be file	Be	17. Father's Name (First, Middle, Last Alfred McDon			18	3. Mother's Name (Smith Mc				
Maryland 21215-0036	hould d Mer marke matic	우	19a. Informant's Name/Relationship		19h Mailin	g Address (Street and	Number or Bural			Zin Code)		
Σ	nd 2 sluth an 27 is a		Shirley McDona	ld wife	12	8 Springda	le Street	Cum	berland	MD 2	1502	
re,	s 1 ar		20a. Method of Disposition	i	Place of Dispos	sition (Name of patory or other place)	Dat		0c. Location - City of			
Ē	Page ment ant: If ury o		1 ☐ S urial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of the Co		illcrest Me	emorial Park	i i	2/3/2009	Cumber	rland	MD	
Baltimore,	permit. Depart Import any inj once.		21. Signature of Funeral Service Lic-	field)	22	Name and Address III 108 Virg			nd, MD 21502	2		
	Physician /Medical Examiner		23a Part 1. Enter the disease, or co	natications that caused the dea	th. Do not ente					Approxim	nate Between	
-			23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respir tory arrest, shock, or heart failure Just only one cause on each line. Immediate Juste (Final disease or condition a. Nohla Auto My custual Aurota 30 mm.									
			resulting in death)	Due to (or as a conse	quence of):			4				
		<u>_</u>	Sequentially list conditions,	b	nuine (A							
	uted I	mine	ir any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conse	quence oi).							
Ć,	s law requires that the death certificate be executed has been signed by the attending physician and e 2 should be detached for use as the burial-transit	resulting in death) Last Due to (or as a consequence of):										
68760,		Medical		d								
39 x	ertifica ing ph e as th	Med	IF FEMALE:	41-5								
Bo	0 2 0		23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of	taldeath 3□	Ectopic pregnancy Other (specify)			23d. Date of o Month	delivery Day	Year	
o.	y the check	ysic	1 □ Yes 2 □ No 9 □ Unknown	9 Unknown	death 3L	Tottler (Specify)						
σ.	that ned b	y P	Part II. Other significant conditions	contributing to death but not re	sulting in the ur	nderlying cause given	in Part I.	23e. Did toba	acco use contribute	to the cause of	of death?	
rds	quires en sign uld be	q pa		<u></u>				1 ☐ Yes	s 2 □ No 3 🔯	Probably 4	Unknown	
9	The law requires that the death ate has been signed by the atter bage 2 should be detached for u	Completed by Physician						24a. Was an autopsy	prior t	autopsy finding to completion o	gs available of cause of	
E E	The arte	Som						perform 1 □ Yes 2	ed? death No 1 □ Y	? es 2□No		
/ita	Ician: The certificate ector, pag	Be (25. Was case referred to medical examiner?	Hamitali			6. Place of Death				_	
of \	Physician: r this certific ral director, i	<u>۲</u>	1 ☐ Yes 2 ☐ Mo	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier		4 LI Nursing Hom		nce 6 Other (S) w injury occurred	oecify)		
on	ding F h. After funer	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year)	Injury	Work?	s 2□No	5d. 2000.130 No.	,,			
Division of Vital Records,	Attending or death. ector: Afte by the fune	Certification: To	3 Suicide 6 Could not 4 Homicide determine	be 200 Place of Injury - At I	home, farm, str	eet, factory, office	28	Bf. Location (Str. City or Town,	eet and Number or State)	Rural Route N	lumber,	
Ö	tal or rs afte at Dir	Cert										
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier 1 Certifying F (Check only 2 Medical Exa	Physician: To the best of my kr aminer: On the basis of examin and manner stated.	nowledge, deat nation and/or in	n occurred at the time vestigation, in my opir	, date and place, a nion, death occurre	nd due to the ca d at the time, da	ause(s) and manner ate and place, and d	as stated. lue to the caus	se(s)	
	To the within To the comple	Me	29b. Signature and little of Centifie			29c. License n		29	d. Date signed (Mo		r)	
) h	will.		Doo	33280		Fan 30,	2009		
			30. Name and address of person who	completed cause of death (Ite	em 23a) (Type,	Print)	ALADAR	. A.	n Mn	2150)	
	Sta	ate.	31. Date filed (Month, Day, Year)	32. Regi y frar's Sign	nature -	Print) DIT AVE	· CUPPIS	HCUIN	17111)	VI 20	~	
	Sta Regist			4 2009 Denous	J. J.	parket						

DHMH 17 Rev 1/2001

Dir

				1 - State Registrar 1. Decedent's Name (First, Middle,			Ce	ertificate	of H	ealth and Death	2. Date of D	Reg. No	200	9 03 14
	П	Physici /Medio		Donald J. Micha	e1						Month	Da		11:35 P ^M
4		Examir		4a. Facility Name (If not institution,		mber)		4b. City,	Town, or	Location of Deat		_	. County of Dea	
	and the second			Stella Maris Ho					noni					imore
		Funeral Director		5. Social Security Number 217-14-1077 Usual Residence of Decedent	3. Sex 1. X M 2 □ F	7. Age (In yrs	s. last birthday Yrs.	If Under Months	Days	If Under 24 Hrs Hours Min.	June 2	Birth Day, Year)	9. Bin C	rthplace (State or Foreign ountry) Maryland
		hours after death with the Maryland tural", or Items 23a or 28a-f show at Evan the most be notified at	ector	10a. State 10b. County Maryland Ba 10e. Street and Number	altimore	10c. C	City, Town or L	Lum						10d. Inside City Limits 1 ☐ Yes 2 🛣 No
		3a or	Ë	2300 Dulaney Ro	ad			10f. Zip	code 21093	2			tizen of What C	ountry?
	98	hin 72 hours after death e. an "natural", or Items 2 Modical Exantonium	Completed by Funeral Director	11. Marital Status 1 ☑ Never Married 2 ☐ Marrie	12. Was Dece Armed Fo 1 XYes	2 □ No			ent of His	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or Note Rican, etc.)	_	14. Race - Am- Black, Whit	
	9	hours tural",	q p	3 Widowed 4 Divorced	Year or D	ates: WW							Specify:	White
	21215-0036	"na	omplet	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	grade completed) College (I-4or 5+)	(Give	edent's Usua e kind of work DO NOT use ectric	k done di e retired)	tion uring most of woi	rking		and of Business	
M.	Maryland	permit. Pages 1 and 2 should be filed within Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, IT. M. ODGE.	To Be C	17. Father's Name (First, Middle, La Joseph Michael	ast)					18. Mother's Nar Lilli	ne (First, Middle e Griff	le, Maiden		
D	Jar	2 sho	(3	19a. Informant's Name/Relationshi			1			nd Number or Ri				
35	e, l	1 and Health em 27 ther t	8	Michael N. Schl 20a. Method of Disposition	eupner, .		<u> </u>				Suite 1			, MD 21044
11:	Baltimore,	ages ent of nt: If Its		1 ☐ Burial 2 🏋 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		State	Place of Disponentery, cre			; I=43	-2009		ocation - City or	
	alţir	mit. F sartme sortan injur		21. Sign state of Funeral Service Li		R • '	2	2. Name and	Address				- 777	, Maryland
	ä	Per la	5 5	Rechard 7.	Clood	le .	R	. T. E	oard	Funera	1 Home,	P.A	City	MD 21915
				23a. Part 1. Enter the disease, or c shock, or heart failure. List or	omplications that only see cause on e	aused the dea	ath. Do not en	ter the mode	of dying	, such as cardia	c or respiratory	arrest,	<u> </u>	Approximate Interval Between
4		Physician	i i	Immediate Cause (Final disease or condition			erfic			245				Onset and Death
		/Medical Examiner		resulting in death)	Due to	or as a conse	quence of):							
	5		e	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a conse	quence of):							
		cuted nd ansit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events	6		,							
60	o,	tificate be executed g physician and as the burial-transit	Exa	that initiated events resulting in death) Last	Due to	(or as a conse	quence of):							_
2009	68760,	cate b physic the br	edical		d									
26,	. Box	death cer e attendin d for use	sician/M	JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No		birth 2 ☐ Fet nant at time of	tal death 3	□ Ectopic pro □ Other (spe					23d. Date of de Month	livery Day Year
UAK	P.O.	that the ed by th detache	Phys	9 ☐ Unknown Part II. Other significant condition				and the second			1 00 Did			
JANUARY	of Vital Records,	requires the second of the control o	Completed by	ratta. Other significant condition	s contributing to de	atri but not re	suring in the L	inderlying ca	use giver	n in Part I.		Yes 2		o the cause of death? robably 4 ☐ Unknown
T	Rec	has b	mple								24a. Wa aut	opsy	prior to	utopsy findings available completion of cause of
IAE	<u></u>	in: The ificate h or, page		25. Was case referred to medical							1 □ Yes	formed? 2 4 No	death? 1 ☐ Yes	2 □No
MICHAEL	=	Physician: this certific al director,	o Be	examiner?	Hospital:	Innationt 2	☐ ER/Outpatie	nt 3 🗆 DO	Other	26. Place of Dea			0.000	
		ig Phy ter thi neral (n:T	27. Manner of Death	28a. Date		28b. Time o		c. Injury Work?		28d. Describe		6 ☐Other (Speny occurred	ecify)
ALI	Sio	Attending r death. ector: Afte by the fune	atio	1-☐Natural 5 ☐ Pending 2 ☐ Accident investiga	tion	in, Day, rear)	injury	М		es 2□No				
DONALD	É	P S F F	Certification: To	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 28e. Place buildi	ng, etc. (Spec					City or 10	own, State	9)	ural Route Number,
		To the Hospital within 24 hours a To the Funeral I completely filled	Medical	one)	Physician: To the kaminer: On the b and man	best of my kn asis of examin ner stated.	nowledge, deat nation and/or in	th occurred anvestigation,	it the tim in my op	e, date and place inion, death occu	e, and due to thurred at the time	e cause(s e, date and	and manner a d place, and due	s stated. e to the cause(s)
_		5 vit	2	29b. Signature and title of certifier	1 m		ND	29c.	License	number 2 PB 2		29d. Da	te signed (Mont	
								Deias	UJ	0 0 0			127	12009
				30. Name and address of person w ROBERT MOSS, A			em 23a) (Type, NEY VAI		7 <i>Z</i> D	TTMONTI	JM , MD .	21002	?	
		Sta		31. Date filed (Month, Day, Year)	#2. R	egistrar's Sign	ature			-+1101111	, 1111		·	
		Registr		FEB 0 4 20	UY Alex	un f	. Joan	Ked						
541	DHM	/IH 17 Rev 1/20	001				-	101111						
DK							OF	IGINAL						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** 2^{Day} 2009 RAT.PH WIT.I.I.TAM MORGAN January 4:34 p. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Middletown

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Min. | May 22, 3 Cone Branch Drive Middletown Frederick 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ▼M 2 □ F Yrs Director 212-14-6097 90 1918 Maryland Usual Residence of Decedent show 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "natical Examinat must be notified at 1 X Yes 2 □ No Director Maryland Frederick Middletown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3 Cone Branch Drive 21769 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 X Married 1 ☐ Yes 2 No Specify. <u>ک</u> Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) it. Pages i and z one attended Hygren...
artment of Health and Mental Hygren...
--rant: if item 27 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) Building Contractor 12 General Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emerson Morgan Flora Edith Brandenburg 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria A. Moore/daughter 206 Lombardy Court, Middletown, Maryland 21769 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of Important: If it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Mark's Lutheran Feb.2,2009 Wolfsville, Maryland 4 ☐ Donation ✓5 ☐ Other (Specify) 21. Signature of Funeral Service iconsee 504 Main Street 22. Name and Address of Facility Ricketts Funeral Home Myersville, MD 21773 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between pset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) W /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that initiated events resulting in death) Last neı Due to (or as a consequence of) Exami burial-transi and Due to (or as a consequence of): physician the burial Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) signed by the a d be detached for ☐Yes 2 ☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ enroval cular 1 🗌 Yes 2 No 3 Probably 4 ☐ Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has page 2 s autop performed 2 No this certificate 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ nours after death.

neral Director: After this

filled in by the funeral di 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

The law requires that the death certificate be executed Box 68760. P.O. of Vital Records, Physician; Division Hospital or Attending 24 hours a within 2

Baltimore, Maryland 21215-0036

Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Sarre

Do968

09

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

300 West 9th Street, Frederick, Maryland 21701 Austin Pearre, MD

State Registrar

Medical

31. Date filed (Month, Day, Year) 0 4 2009



09-00731	
Louise Mumma	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3

ouise Mumma	State of Maryland / Dep	partment of ertificate of			2009 0314
Physician/ ledical Examine	Decedent's Name (First, Middle,Last)		Mumma	2. Date of Deat Month January 24	th 3. Time of Death
	Facility Name (if not institution, give street and number) T50 Dual Highway	4	b. City, Town, or Location of Hagerstown		4c. County of Death Washington
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs 217–28–1239 1 M 2XF 7	s. last birthday) 7 Yrs.	If Under 1 Year If Under 1 Months Days Hours	Min.	th(MM/DD/YYYY) 9. Birthplace (State or Foreign
aux	Usual Residence of Decedent	ity, Town or Location	on	April	3, 1931 Country) Maryland
* *	MD Washington H	lagerstow	n 10f. Zip Code	137	1 Yes 2 X No
h the Maryland 3a or 28a-f sh toiffied at once			21742		U.S.A.
, MD 21215-3036 and 2 should be filed within 72 nours alber death with the Maryland teenlth and Manell Hygieste than "natural", or items 33a or 28a-fish traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 X No 3 X Widowed 4 Divorced If Yes, Give Yeer	If Ye	Decedent of Hispanic Origins, specify Cuban, Mexican Yes 2 X No specify:	, Puerto Rican, etc.)	- 14. Race - American Indian, Black, White, etc. Specify: White
72 hours alla n "natural" al Examine leted by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	16a. Decedent	's Usual Occupation (Give est of working life, DO NOT	kind of work done	16b. Kind of Business/Industry
21215-0036 Mental Hygiene. marked other than "mature event, the Medical Exam	17. Father's Name (First, Middle, Last)	Seamst		's Name (Firs., Middle, N	Manufacturing Maiden Surname)
Baltimore, MD 21215-005 permit Pages I and 2 should be filed with Department of Health and Mental Hygiene Umportant: I filem 27 is marked other tining or other traumatic event, the Med Toll Be Corni	Ignatius Drury 19a. Informant's Name/Relationship (Type, Print)	19b. Mailing		e Virginia	Henson nber, City or Town, State, Zip Code)
nore, MD 2 ages 1 and 2 shou nt of Health and N tt: If item 27 is n other traumatic		 b. Place of Disposi 	tion (Name of cemetery,	d, Clear Sp	oring, MD 21722 20c. Location - City or Town, State
Baltimore, permit Pages I are Department of Flee Important: If ite Important or other tr	1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee		n Cemetery ame and Address of Facility	1/30/2009	Hagerstown, MD
	23a. Pa Finter the disease, or complicators that caused the dea	160	01 Pennsvlvai	nia Ave H	n Funeral Chapel agerstown, MD 21742 est, s ack, or heart Approximate Interval
Physician /Medical kaminer	failure. List only one cause on each lind. Immediate Cause (Final disease a. <u>Hypertensive</u>	e atheros			Between Onset and
/s	Sequentially list conditions.				
ed nsit Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence	e of):			
be execultion and urial - tra		H I,27,per	ME, g890-4/2	!2/09 TT	
box 68760, the death certificate be executed by the attending physician and ched for use as the burial - transi Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 ✓ No 9 Unknown 23c. If yes, outcome of pr	2 Fet	al death 3 Ectopi er (Specify)	c pregnancy	23d. Date of delivery Month Day Year
, P.O. E ires that the c signed by the be detached down Phy	Chronic obstructive pulmor	-		4	obacco use contribute to the cause of death? s 2 No 3 Probably 4 ✔ Unknown
cords law requi				24a. Was autop perfor	prior to completion of cause of med?
f Vital Rec Physician: The this certificate ral director, page To Be Con	25. Was case referred to medical examiner?	ER/Outpatient	26.Place of Death 3 DOA Other	-	Residence 6 ✓ Other: Scene
on of vending Physically. or: After the funeral	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day, Year)	28b. Time of Ir	ijury 28c. Injury at Work		how injury occurred
Division o Division of Attending within 24 hours after death. To the Finneral Director: Aft completely filled in by the fune edical Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)	t home, farm, stree	t, factory, office building, e	tc. 28f. Location (S or Town, S	Street and Number or Rural Route Number, City state)
Div To the Hospital or within 24 hours aft To the Funeral Di completely filled in	29a. Certifier 1 Certifying Physician: To the best of my knowl one) 2 Medical Examiner: On the basis of examination and manner stated.	-			
T × × × ×	29b. Signature and title of certifier Theodore M. Kerry JF.		29c. License number O.C.M.E.	OCME	29d. Date signed (Month, Day, Year) January 26, 2009
	36. Name and address of person who complete cause of death (Ite Theodore M. King, Jr., MD. Assistant Medica	em 23a)	111 Penn Street, Ba	Iltimore, MD 21201	1
State Registra	31. Date filed (Month, Day, Year) 32. Registrar's Sign	nature	well of		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 . Decedent's Name (First, Middle, Last 2. Date of Death Month **Physician** MCCANN NINA 14:42 M JANUARY 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F **Director** 11/03/1935 223-44-2301 73 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28a-f sho her must be notified at Director 1 ☐ Yes 2 🟋 No VA Prince William Woodbridge 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? be filed within 72 hours after death with Funeral U.S.A. 2111 Patrick Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. the Medical Examiner 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 ō 1 ☐ Yes 2 X No White If Yes, Give Year or Dates: ģ Specify: 3 Widowed 4 Nivorced "natural", Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 and 2 should be filed within Health and Mental Hygiene. em 27 Is marked other than College (1-4 or 5+) 12 Bookkeeper Retail traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Bernard White Unavailable 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any Injury or other trau
once. Gregg Fields/Son 10816 Stacy Run Fredericksburg, VA 22408 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mount Comfort Cemetery 1/24/09 Alexandria, VA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Mountcastle Funeral Home cki 21 13318 Occoquan Road, Woodbridge, VA 22191 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Respiratory Distress disease or condition resulting in death) /Medical Due to (or a consequence of) Examiner Sequentially list conditions if any cause Inter Underlying Cause (Disease or injury that initiated events Examiner physician and sthe burial-transit death certificate be executed Meloablative resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) ate has been signed by the all page 2 should be detached t 2 No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' certificate 2 No 1 🗌 Yes 2 🗌 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, to Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 X Inpatient Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred Division 1 X Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) JANUARY, 19, 2009 RES-000 , MEDICAL DOCTOR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LIMKETKAI, HOPKINS BERKELEY JOHNS 600 North Wolfe St, Baltimore, MD, 21287 HOSPITAL,

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year January **Physician** David Xavier Clement Ng 10:50 P ^M 2009 16, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Rockville Casey House-Montgomery Hospice If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Days Months 1 X M 2 □ F 023-14-3010 84 New York 31, 1924 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State 28a-f show th and Mental Hygiene. 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be rudfled at 1 ☐ Yes 2 X No Maryland Montgomery Bethesda Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 20817 United States 6530 Democracy Boulevard Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1⊠Yes 2□No World
If Yes, Give
Year or Dates: War II 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify Specify: ģ Asian 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Sales Self Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Chew She Wing Ng ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 Is any injury or other trau once. 9013 Kirkdale Road, Bethesda, MD 20817 Myriam S. Bahiman (Friend) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition January 2008 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 23 Crownsville Cemetery Crownsville, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Fyneral Service Ucen 10 E. Deer Park Drive, Gaithersburg, MD 20877 23a. Part 1. Effect the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line.

Immediate the disease or dillion resulting in death)

Congestive Heart Failure

Due to (or as a consequence of): Approximate Interval Between Onset and Death Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ Gastrointestinal Bleed, Atrial Fibrillation, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? Diabetes Mellitus, Dementia 24a. Was an performed? 1 ☐ Yes 2 🖺 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check onl one) Other: 4 Nursing Home 5 Residence 6 AOther (Specify) Hospice Hospital: 1 ∐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month. Dav. Year) 29c. License number 29b. Signature and title +1 D0065 024 of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address MONIQUE 18101 Prince Philip Drive, Olney, MD 20832 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 21 Registrar

Division of Vital Records, P.O. Box 68760,

				Plea	se Type or								-		-	le.	
			For State Registrar		State	of Mar	yland				lealth and Death	d Me	ntal Hy	•	$Z \cup U$	9 0	3146
			Registrar 1. Decedent's Name	e (First Midd	le. I ast)			Cer	unca	ie or i	Dealii	2	Date of De	Reg. No) .	3	Time of Death
	Physici /Medic				pier, Jr.								Month Janna	Da		o ar	3 32A M
	Examin		4a. Facility Name (/ Holy Cro			umber)			4b. City		Location of De er Spri			4c	. County of Mon	Death tgomer	y
	Funeral Director		5. Social Security N 458-14-		6. Sex XIX M 2□ F	7. Age	(In yrs. last 86	t birthday) Yrs.	If Unde Months	Days	If Under 24 F Hours M	in.	Date of Bi (Month, D uly 1	a <i>y</i> , Year))	. Birthplace Country) Arkans	(State or Foreign
	pur *		Usual Residence of 10a. State	Decedent 10b. County	,	1	10c. City, T	own or Lo	cation							10d J	nside City Limits
	Maryla f sho	ō		,	ntqomery			ilve		cina							□Yes 2¶∑No
	r 28a	Director	Maryland 10e. Street and Nur		iregomery			111001		p Code				10g. Ci	tizen of Wha	at Country?	
	ath wit	ral	3124 G	racefi	eld Road,	#41	7			209					USA		
215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Modical Examinar must be notified at	by Funeral	11. Marital Status 1 ☐ Never Marri 3 ☐ Widowed		If Yes (Forces? 2 [X No Give			Was Deco fYes, sp 1 □ Yes		lispanic Origin? an, Mexican, Pu Specify:	(Specif erto Ric	y Yes or No can, etc.)	0-		American Ir White, etc. Whit e	
5-0	72 ho	eted	(Spec	15. Deceder	nt's Education est grade completed	i)	1	16a. Deced	dent's Us kind of w	ual Occup ork done	ation during most of v	vorking		16b. K	(ind of Busin	ness/Industr	/
2121	within ene. than'	Completed	Elementary/Seco	ondary (0-12)		(1-4or 5+)			iste:		d)			Luit	heran	Churc	·h
d 2	filed Hygi other ent, t	Be Co	17. Father's Name	(First, Middle,							18. Mother's N	lame (F	First, Middle			Ollard	
/lar	uld be Menta arked	To B	Carl He	nry Na	pier, Sr.	•					Ida	Rue	dy				
Maryland	2 sho n and is ma rauma		19a. Informant's Na	ame/Relations	ship (Type. Print)			19b. Mailir	ng Addres	s (Street	and Number or	Rural F	Route Numl	ber, City	or Town, St	ate, Zip Cod	e)
e,	1 and 2 Health a tem 27 is				r/Wife							_					
mor	Pages ent of nt: If it		1 ☑ Burial 2	Cremation		n State						Ja	n. 23	,			
Baltimore,	permit. Pages 1 Department of I Important: If ite any Injury or ot once.			Ruth C. Napier/Wife 3124 Gracefield Road, #417, Silver Spring, MD a. Method of Disposition 1												yland	
8	8 8 E 8		do.	s S	r complications that			5	00_U	iver	sity_B1	vd.	. W.	Sil		pring,	MD 2090
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68760,	To the Hospital or Attending Physician. The law requires that the death certificate be executed within 24 hours after death. Jo the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	_	resulting in death)	Last			consequen										
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			30. Name and add	T · PVT	HUMANA	3111	ath (Item 2)	3a) (Type,	Print)	D Rû	AD, SIL	VER	SPRI	NG,	MD 2	20904	+
	Sta Registi		31. Date filed (Mor	IN 21	2009	Hegistrar	s Signatur	Span	Kad.								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Charles Edwin Nock, Sr. 0055 PM 01 20 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner NICIM 100 514136424 REGIONAL TENINSULA (In yrs. last birthday) 93 Yrs. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year) 1/29/1915 Birthplace (State or Foreign Country) **Funeral** Days 1 XM 2 ☐ F 215-18-4676 MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene. Important; if item \$23a or 28a-f show important; if item \$7 is marked other than "natural", or items \$2a or 28a-f show alway injury or other traumatic event, the Medical Examinational that he notified at once. 1 ☐ Yes 2 No Director MD Worcester Pocomoke City with the 10g. Citizen of What Country? 10e. Street and Number 2409 Ward Rd. 21851 by Funeral USA death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 □Yes 2X No 1 Never Married 2 Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🕱 No Specify: 3X Widowed 4 □ Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Farmer Poultry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gordon E. Nock Sarah Hadder ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Linda N. Figgs / daughter 100 Powell St., Snow Hill, MD 21863 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Spring Hill Cemetery: 1/25/09 Girdle Tree, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burbage Funeral Home 21. Signature of Funeral Service Licensee 108 William St., Berlin, MD 21811 23a. Paryl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Who word **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner schemas Sequentially list conditions, if any leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or go a concequence of): Physician: The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-transi Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, <u>۾</u> McVI 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ vinknown been si Completed ial or Attending Physician: The law nes after death.

I Director: After this certificate has be ed in by the funeral director, page 2 sh 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an 1 □Yes 2 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital or within 24 hours at To the Funeral D 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BA 3 STEVEN HEARNE 100 € 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 2 2009 Registra Jack to

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 16, 2009 9:50P Charles F. Olsen January /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Mandrin Chesapeake Hospice House Harwood 8. Date of Birth Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 ₹M 2□ 5/19/1932 New Jersey 76 219-32-4750 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 X No Annapolis Directo Maryland | Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21401 USA 106 Harbour Heights Drive Funeral Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 NYes 2 No Korean If Yes, Give Year or Dates: War 1 Never Married 2 Married 1 ☐ Yes 2 🖫 No Specify: White Specify Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☑ Divorced War 16b. Kind of Business/Industry Completed 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Professor of Engineering US Naval Academy 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be Clarence E. Olsen Vivian Louise Sprink 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kurt B. Olsen/Son 13317 Drews Lane Potomac, MD 20854 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Kalas Crematory 1/20/2009 Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility George P. Kalas Funeral Home alas 2973 Solomons Island Rd. Edgewater, MD. 21037 Approximate Interval Between Onset and Death hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complishock, or heart failure. List only or LUNA cancer Immediate Cause (Final MOS Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and as the bunal-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Completed by Physician/Medical IF FEMALE: . If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? should be detached for 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No s certificate has be lirector, page 2 s 1∐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, p 26. Place of Death (Check only one 25. Was case referred to medical Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSP)(2 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28d Describe how injury occurred 28a. Date of Injury (Month, Day Year, 28b. Time of 28c. Injury at Work? 27. Manner of Death 1 Natural 5 Pending M 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and diress of person who completed cause of death (Item 23a) (Type, Print) Study E. Scionicus, MO 900 Bestgate Rd. Annapolis, Md. 21401 E. Selonick, Mo Stucivt 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 0 2009 Registra

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 12:45 pM Peggy A. Pitts January 09 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery Rockville Shady Grove Adventist Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🛛 F March 21, 1943 District of Columbia Director 65 577-58-6670 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h. County 1 ☐ Yes 2 No Director Montgomery Village Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20886 U.S.A. 8801 Rosemark Court Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 If Yes, Give 2 No 1 ☐ Yes 2 ☒ No Specify Specify. 3 X Widowed 4 Divorced Year or Dates White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louella Cook 2 Marshall Lee Magee 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cindy Halpert - Daughter 25101 Highland Manor Court, Gaithersburg, Maryland 20882 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/22/2009 Cheltenham, Maryland Veterans Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Anoxic Encerhalorathy /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): physiciar Physician/Medical the attending properties for use as 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☒ No ed by the detached 9□Unknowr 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 【 No 24a. Was an autopsy performed' certificate 1<mark>∏</mark> Yes 2□No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2[X] No 2 ER/Outpatient 3 DOA 1 ☐ Yes 1 Inpatient P this funeral 28a. Date of Injury (Month, Day Year) I Director: After to d in by the funera 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? Certification: or Attending 5 ☐ Pending investigation 1 🙀 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide after Hospital within 24 hours a To the Funeral I 1 😾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) January 10, 2009) (12 P 2 J (1) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive, Rockville, Maryland 20850 Brian Carpenter, M.D.,

State Registrar 31. Date filed (Month, Day, Year) JAN 20

Baltimore, Maryland 21215-0036

Box 68760.

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Division or Vital Records,

		For State Registrar	State of Ma	aryland	/ Depa	artment of rtificate o	Health and f Death	Mental Hy	/giene Reg. No. 2 (009	03150
	9	Decedent's Name (First, Middle, La.	st)					2. Date of De	eath		3. Time of Death
Physicia		Yvette Adine Pa	rtington					Janua	ry 17,	2009	9:45 p M
/Medic Examin		4a. Facility Name (If not institution, giv				4b. City, Town,	or Location of Deat	h		y of Death	-
	"	Holy Cross Hospi	ital			Silv	er Spring	Ī	Montgo	omery	
Funeral Director		026-05-9530	ex 7. Age □ M 2 F 98	e (In yrs. las	st birthday) Yrs.	If Under 1 Yea Months Day		(Month, D	2, 1910	Cou	place (State or Foreign ntry) sachusetts
/aryland f show	or	Usual Residence of Decedent 10a. State 10b. County		,	Town or Lo	cation r Sprinc					10d. Inside City Limits 1 ☐ Yes 21 No
3a or 28a-	al Director	Maryland Monto 10e. Street and Number 3114 Gracefield	nomery		SIIVE.	10f. Zip Code			10g. Citizen of	What Cou	ntry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1			Was Decedent o If Yes, specify Cu 1 □Yes 2 🕱 N	f Hispanic Origin? (Suban, Mexican, Puer o Specify:	Specify Yes or N to Rican, etc.)		ace - Ameriack, White,	
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and 2 sh ealth and n 27 is m er traum		19a. Informant's Name/Relationship (Allen V. Parting		đ		-	et and Number or R ield Road				ng, MD 2090
ages 1 sent of He art: If item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 🕱 Other (Special		cer	netery, crei	osition (Name of matory or other p	i Ji	Date an. 22,	20c. Location		
permit. Departm Importal any Inju		21. Signature of Funeral Service Licer		. 4	F ²	2. Name and Add	ress of Facility Collins	2009 Funera	1 Home	Inc.	ng,MD 20901
Physician /Medical		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused one cause on each line. a. Pneumon Due to (or as	ia.	Do not en						Approximate Interval Between Onset and Death
ficate be executed I physician and sthe burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as c. Due to (or as d.	a conseque	nce of):						
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as:	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal c	leath 3	☐ Ectopic pregna				ate of deliv	very Day Year
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ending P sath. or: After I he funera	ation:	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigatio			28b. Time of Injury	V	jury at ork? □Yes 2□No	28d. Describe	how injury occu	irred	
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e Hospit 24 hour e Funera	Medical (nysician: To the best miner: On the basis o and manner st	f examination							
vithir To th comp	Me	29b. Signature and title of certifier	Puthun	an	S M	29c. Lice	nse number D59524	Į.	29d. Date sign Janua		Day, Year) , 2009

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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

State Registrar 3110 Gracefield Road, Silver Spring, MD 20904

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Loveen Puthumana, MD

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2009 Ersa Elizabeth Poston Jan. 5:15p M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Montgomery Bethesda If Under 1 Year | If Under 24 Hrs. 5, Social Security Number 8. Date of Birth Month, Day, 3 5/3/1921 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours Min. Year) 1 ☐ M 2 🙀 F 87 285-22-0736 Kentucky Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Montgomery Chevy Chase 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4701 Willard Avenue 20815 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 21 No Specify: Specify: Black 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Civil Service Commiss Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Robert Hines Vivian Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl Tyler / Niece 1363 Somerset Place, NW Washington, DC 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🔁 Cremation 3 ☐ Removal from State Chesapeake Crematory 1/19/2009 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McGuire Funeral Service, Inc. hompo 7400 Georgia Avenue, NW Washington, DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Pneumonia 14 days Due to (or as a consequence of): Dysphagia 14 days Due to (or as a consequence of): Dementia Years Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2x No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 X No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔼 Inpatient 2 ER/Outpatient 3 DOA

The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records,

Physician

/Medical

MD

Director

Funeral

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Completed

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Examiner

Funeral

Director

ral", or items 23a or 28a-f show Examinar roust be notified at

the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with to Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "not any injury or other traumating once.

Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events been signed by the attending physician and should be detached for use as the burial-trar resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Tyes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Diabetes Mellitus, Hypertension, Malnutrition Chronic Kidney Disease After this certificate has funeral director, page 2 : To the Hospital or Attending Physician: "within 24 hours offer death.

To the Funeral Unrector: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 5 ☐ Pending investigation 1 X Natural 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated 29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29c. License number 29d. Date signed (Month, Day, Year)

1/8/09 Shyamsundar Rajan, M.D.

D53367

State Registrar 31. Date filed (Month, Day, Year) JAN 21



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	State of Maryland	•	tificate of E		гептат туді Re	g. No. 2009	03152
	Physicia		1. Decedent's Name <i>(First, Middl</i> e, La Jean	Eleanor		Pownall		2. Date of Death Month	Day Yeer	3. Time of Death 7 1/45 M
	/Medic Examin Funeral	er	4a. Facility Name (If not institution, given by Social Security Number 6.5. Social Security Number 6.5.	SPITAL Sex 7. Age (In yrs. I	last birthday) . Yrs.	4b. City, Town, or COUBC If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) Co	thplace (State or Foreign
	Director wows		OP - A - 52 O	10c. City	y, Town or Loc	eation		02/04/19	923 Rho	de Island 10d. Inside City Limits 1 □ Yes 2 ☑ No
	with the Manager of t	al Director	10e. Street end Number Route 4 Box 66	41	71148	10f. Zip Code	753	10	g. Citizen of What Co	
020	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:		Vas Decedent of His fYes, specify Cubar □Yes 2√ No	spanic Origin? (Sp. n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
N-0171	within 72 hou iene. than "natur ne Medical E	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	(Give life. L	lent's Usual Occupa kind of work done d DO NOT use retired, emaker	uring most of work		6b. Kind of Business/	
סכ	- 0 W	Be C	17. Father's Name (First, Middle, Las	1)			18. Mother's Name	e (First, Middle, M	laiden Surname)	
Уlä		To E	Walter	Eugene	T	Ricker	Adelia		Mabel	Howard
Mar	12 s h ar 7 is trau		19a. Informant's Name/Relationship Helen E. Bingham		1	g Address <i>(Street a</i> te 4 Box			City or Town, State, 26753	zip Code)
Baltimore, Maryland 21215-003	permit. Pages 1 and Department of Healt Important: If item 2' any Injury or other once.		20a. Method of Disposition 1X Burial 2	ify) Pot	comac M		Gardens O	1/18/200 ms Famil		
	ificate be executed Medical Physician and physician and street prival-transit is the purial-transit	edical Examiner	disease or condition resulting in death) Se prentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Duy to (or as a consequence of the consequence o		unour	ng am			
P.O. Box 6	the death certific y the attending p ched for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of a	aldeath 3	Ectopic pregnancy Other (specify)	<i>y</i>		23d. Date of de Month	elivery Day Year
rds, r.	law requires that the de as been signed by the 2 should be detached	þ	Part II. Other significant conditions	contributing to death but not res	ulting in the u	nderlying cause give	en in Part I.			o the cause of death?
al Reco	1: The law re ficate has bee r, page 2 sho	Completed					ac Slove of Deci		y prior to ned? death? 2 ☑ No 1 ☐ Ye	utopsy findings available completion of cause of
<u> </u>	yslcial is certi directo	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 Inpatient 2] ER/Outpatier	nt 3 DOA Othe	DE:	th <i>(Check only one</i> ome 5 Reside	ence 6 Other (Spe	ecify)
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Certification: To	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigati 3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	28a. Date of Injury (Month, Day, Year) on be 28e. Place of Injury - At h	28b. Time o Injury	f 28c. Injur Work M 1 🗆	y at ⟨? Yes 2 □ No		reet and Number or Fig. State)	dural Route Number,
	e Hospital 124 hours a e Funeral (letely filled	Medical Ce	29a. Certifier (Check only one) 1 Certifying 1 Certifying 2 Medical Ex	Physician: To the best of my kn aminer: On the basis of examin and manner stated.	owledge, deal ation and/or ir	th occurred at the tinvestigation, in my c	me, date and place	e, and due to the c rred at the time, d	ause(s) and manner a ate and place, and du	as stated. e to the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifier			29c. Licens	e number		9d. Date signed (Mon	th, Day, Year)
	TIMS		30. Name and address of person wh	EMA M.D.	2005	TIMIT	De., ONL	BERLAN	DM OR	21502
	St Regist	ate rar	31. Date filed (Marth 17, 6°a 20	32. Registrar's Sign	par	Ked				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra AMFND#20loper:FH1/23/09, BMW, MoCo Certificate of Death 2. Date of Death 000H 2004 WULL THY 4a. Facility Name (If not institution, give street and number) Washington 4c. County of Death Town or Location of Death montgo Lochville -Hebrew Home of Greater 8. Date of Birth (Month, Day, Year) 01/27/1913 f Under 1 Year If Under 24 Hrs. 6. Sex Days Months Min. Connecticut Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 XYes 2 No Rockville Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20852 6121 Montrose Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Specify: Specify. 3 Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Grocery Store Owner 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rose Levine Morris Yoselevsky 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20854 8509 Wilkes Boro Lane, Potomac, Maryland Sandra Davis, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place). Norwich Jewish Fraternal 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State 01/20/2009 Norwich, Connecticut 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.
1170 Rockville Pike, Rockville, Maryland 20852 OSCIEROTIC CYARVIOVASCULUR DISES Approximate Interval Between Onset and Death equence of): 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death)

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it is Medical Examitter is used by notified at

Baltimore, Maryland 21215-0036

Examiner Be Completed by Physician/Medical Medical Certification: To To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Sequentially leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2√1No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pre 4 Pregnant at time of death 5 Other (spec			23d. Date of delivery Month Day Year
Part II. Other significent conditions of	ntributing to death but not resulting in the underlying cau	se given in Part I.		se contribute to the cause of death?
			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical examiner?	lospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	26. Place of Death ((Check only one)	6 □ Other (Specify)
27. M. no r of Death 1 V. Natural 5 Pending 2 Accident investigation			3d. Describe how injur	y occurred
3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, obuilding, etc. (Specify)	office 28	Bf. Location (Street an City or Town, State	d Number or Rural Route Number,)
29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	sician: To the best of my knowledge, death occurred a ner: On the basis of examination and/or investigation, i and manner stated,	t the time, date and place, and my opinion, death occurred	nd due to the cause(s d at the time, date and) and manner as stated. d place, and due to the cause(s)
29b. Signature and title of certifier	Lally 29c.	D 35430	5 JA /	te signed (Month, Day, Year) 1442717, 2007
30 Name and address of person who	ompleted cause of death (Item 23a) (Type, Print)	MONT POSE	ED Rick	LVIUE MOZIASE

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1 Decedent's Name (First Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 8:45 am Ethel Teaco White Rudd January 10 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Potomac Potomac Montgomery If Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days 1 □ M 2 1 F AUG. 94 1914 Connecticut Director 041-10-5697 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location show the Medical Exarcitors count by cottified at 1 XYes 2 No Director Potomac Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō 20854 Items 23a 10714 Potomac Tennis Lane United States of America by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married Maryland 21215-0036 "natural", or 1 ∐Yes 2 XNo Specify. Specify: Black 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) within 72 (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 in and Mental Hygiene. 7 ia marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) 12 Store Owner Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ethel Teaco Jones James H. White ೭ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sl Department of Health an Important; If item 27 ia r any Injury or other traur 10419 Boswell Lane, Potomac MD 20854 Carol Hudgins - Daughter Saltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft Lincoln Crematory 1/21/2009 Brentwood, Maryland 21. Signature of Fune al Service Licensee 22. Name and Address of FacilitySimple Tribute Funeral & Cremation 1040 Rockville Pike, Rockville, MD 20852 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease shock, or part failure. Immediate Caus (Final disease or contion resulting in death) Physician Failure to Thrive /Medical Due to (or as a consequence of): Examiner Advanced Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed attending physician and for use as the burial-transi Arteriovascular Disease Due to (or as a consequence of) P.O. Box 68760, Physician/Medical Arteriosclerosis IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a The law requires that the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 類 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? Yes 2 ☑No this certificate ospital or Attending Physician: Trhours after death.
neral Director: After this certificate y filled in by the funeral director, pag 1 ☐Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∏Yes 212No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 4 Natural 28b Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 □Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Hospital 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D31319 January 13, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

LOI 6 31. Date filed (Month,

Loreto S.

#305, Bethesda, MD 20814

Aldiol, MD 8218 Wisconsin Ave

			State of Maryland /		artment of H		nd Mental I		20	09	03155	
			Registrar 1. Decedent's Name (First, Middle, Last)		unicate of L	Jeani	2. Date of		No. Z. U	0 9	3. Time of Death	
*	Physicia		Annette Robinson				Month		Day 13 200	Year	1:15 ^{P M}	
	/Medic		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of	Janua Death		4c. County o		1:15	
L			Wilson Health Care Center		Gaithe				Mon	tgome	ery	
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<u>ق</u>	s 1 and 2 f Health Item 27 other tra				sition (Name of matory or other place		Date		Location - C		<u> </u>	
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Baltimore,	permit. Page Department of Important: If any injury or once.	1	21. Signature of Funeral Service Licensee		2. Name and Addres							
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Division or	Attending Physician: r death. ector: After this certifics by the funeral director, p	icat	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of injury - At home,	farm, str		165 2 1		on (Stree	 t and Numbe	r or Rurai	Route Number.	
<u>S</u>	after after Dire d in b	Certification:	4 Homicide determined building, etc. (Specify)					Tòwn, S				
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			30. Name and address of person who completed cause of death (Item 33a / L. C. B. R. T. B. R. C. C. C. B. R. C. C. B. R. C. C. C. B. R. C.	1,11	D 2.6	HITH	ERSBUR	16,1	us.	201	13,2009	
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DHMH 17 Rev 1/2001

Baltimore. Maryland 21215-0036

Division of Vital Records. P.O. Box 68760.

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Physicia /Medic	al .	John Alan										01	18	0	9	0119	М
Examin	er	4a. Facility Name ((If not institution RADDOCK)			, Town, or UMBEF				4c.	County o	of Death EGAN	v	
Funeral		5. Social Security N		6. Sex		ge (In yrs. i	last birthday) If Unde	r 1 Year	If Unde	r 24 Hrs.	8. Date of Bi	rth	ALL	9. Birthp	lace (State o	or Foreign
Director		386-32-90	089	1 N M		78	Yrs.	Months	Days	Hours	Min.	(Month, December	-	30	Coun	yland	
and and		Usual Residence of 10a. State	f Decedent 10b. County			10c. City	y, Town or L	ocation							1	0d. Inside C	ity Limits
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ours at	ρ	3 Widowed		If Ye	Yes, Give ear or Dates:	Conf	lict	1 □Yes	2 No	Specify	/:			Specify:	Whit	te	
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al Hyg other	BeC	17. Father's Name	(First, Middle,							18. Moth	ner's Name	e (First, Middle				<i>A</i> .	
Menta Menta arked atic e	70	Henry R	izer							An	na Col	eman					
12 shoth and 7 is mtraum		19a. Informant's N									_	al Route Numb				,	
tem 2		Ann Cole 20a. Method of Dis		(daughter	20b. F	Place of Disc	4 Old Nosition (Na	ame of			stburg Date		Mary cation - 0		2153 wn, State	2-
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permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Inportant: If Item 27 is marked other than "natural", any injury or other traumatic event, It a Modical Exagence.		21. Signature of E	uneral Service	Licensee			2	22. Name a			•		1				
20E # 9		00- 0-4 5-40	obefor!	1	1015	1 45 2 1 2 2 4	h Danata					Frost Ave		tburg,	MD :	21532 Approximat	
Dharistan		23a. Part 1. Enter shock, or hea Immediate Cause	art failure. List	only one car	is that cause use on each	ine.	n. Donot el	ner the mo	de or dyll	ng, such a	is cardiac	or respiratory	arrest,			Interval Bel	ween
Physician /Medical		disease or condition resulting in death) Table 1900 Chouse 1900 C											\rightarrow	481	10MS.		
Examiner		Sequentially list co	onditions.	b													
ted	Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease of	nmediate erlying er injury	ł	Due to (or as	s a conseq	uence of):										
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1 50 86	Physician/Medical	IF FEMALE:		23c If	yes, outcom	e of pregna	ancv										
death cer	ician	23b. Was deceder in the past 12 1 ☐ Yes 2	2 months?	1 4	Live birth Pregnant	2 ☐ Feta at time of o	l death 3	☐ Ectopic		СУ			2	Mor	e of deliventh		Year
that the de the by the c	hysi	9 Unknowr		9	Unknown												
res thi	ρ	Part II. Other signi	ificant conditi	ons contribu	ting to death	but not res	ulting in the	underlying	cause giv	en in Part	I.		tobacco u Yes 2[ibute to th 3 Prob	ne cause of o	death? , Unknown
w requires we requires so should be a	eted													r			
The lav	Completed												opsy formed?	p d	rior to co eath?	psy findings mpletion of o	available cause of
	e e	25. Was case refe	erred to medica	ıl	-					26. Plac	ce of Deat	1 ∐Yes h (Check only		1	□Yes	2 No	
hysician: this certific	To B		No	Hospi	npa		ER/Outpati			4 L r	Nursing Ho	ome 5□Res	sidence 6	6 □Othe	er (Specif	y)	
ng F	ion:	27. Manner of Dea	5 🗌 Pendir		Ba. Date of In (Month, D	jury a <i>y, Year)</i>	28b. Time Injury	of M	28c. Injur Wor	ryat k?]Yes 2.[¬No	28d. Describe	how injury	y occurre	ed		
Atten r deati ector: by the	Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	6 Could		Be. Place of Ir	njury - At h	ome, farm, s			1163 2		28f. Location			er or Rura	l Route Nun	nber,
ital or rs afte	Cert	4 LI Homkdide			bullaing, e	etc. (Specia	(y)					City or 10	own, State,				
the Hospital hin 24 hours a the Funeral I	Medical	29a, Certifier (Check only one)	1 Certifyi 2 Medical	Examiner:	n: To the bes On the basis and manners	of examina	owledge, dea ation and/or	ath occurre investigati	ed at the ti on, in my o	ime, date : opinion, d	and place eath occu	, and due to th rred at the time	e cause(s) e, date and	and ma place, a	nner as s and due to	tated. the cause(s	6)
To the Hospital or Atendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Mec	29b. Signature and	d title of certific		and mailners	naieu.		2	9c. Licens	se number	·		29d. Dat	e signed	(Month,	Day, Year)	
11.+		W	nsor	fell	in	MD)		Doc	553	325		Jan	n 1	8,	2000	
Shorts		30. Name and add		who comple	ted cause of	death (Iter	m 23a) (Type	e, Print)	100	WAI	sn b	D Cus	who	lun	di	1001	500
Sta	te	31. Date filed (Mo		2117	32. Regis	trar's Sign	ature 4	الديد و	-4	V POL	-1. 4-	y cur	V 1.75- L	- IWIL		11/4/	302
Registr		31	ANZU	ZUUS /	Serve	1 10.	Made	Land State of State o									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 7:47 AM Danuary 2000 obest \mathcal{D} /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Lento Wimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number A Sex **Funeral** Months Days Min. Hours 1 □ M 2 🔀 F 38 WashingtonDC 244-49-1851 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Greenbelt filed within 72 hours after death with the Maryland 10a State 10b. County show d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at Prince George's TV Yes 2 □ No MD **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20770 7818 Vanity Fair Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: Black 1 Never Married Married 1 □Yes 2 No Maryland 21215-0036 ⋧ 3 Widowed 4 Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) US Army Human Resource Specialist 12 should be filed with and Mental Hygiei 7 is marked other the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Paulette Morehead James Smith 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 to Department of Health at Important: If item 27 is any injury or other trau 7818 Vanity Fair Dr. Greenbelt, MD. 20770 Dion Robertson/Husband Baltimore, 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Riverdalery Park Crematory Riverdale Park, MD 1/21/09 22. Name and Address of FacilityBriscoe-Tonic Funeral Home 21. Signature of Funeral Service Licensee Kimberly Chrisca 10016 2294 Old Washington Rd. Waldorf, MD. 23a. Parl 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner lumon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 5 burial-trar Due to (or as a consequence of): attending physician for use as the buria P.O. Box 68760 Physician/Medical Intu yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 1 Live birth 2 Fetal death Month Day 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached it q∏Unknown law requires that the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Records, 1 ☐ Yes 2 🔀 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Hospital or Attending Physician: The 2 XN0 2 NO 1 ☐ Yes Vital 26. Place of Death (Check only one) Be (25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Division 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No ours after death.

neral Director: Air filled in by the fur 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

completely within 2 To the I

State

(Check only one)

29b. Signature and title of certifier

\$1. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

2120

2000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 21 2009 Olney Perry Ross 2:48 p.M Jr. January /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Chesapeake Woods Center Cambridge Dorchester If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Year) Months Days Hours 1**⊠** M 2□ F 30, 217-10-8278 89 1919 Director Oct. Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylas nent of Health and Mental Hyglene.
sint: if flean 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, its Modes Examine must be notified any or other traumatic event. 1 XYes 2 No Director MD Dorchester Cambridge 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1419 Stone Boundary Road 21613 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1★IYes 2 □ No If Yes, Give Year or Dates: ₩₩II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: white ğ Specify: 3 ₩ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) conveyor belt mfg. sales manager 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Olney Perry Ross Hester Travers ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kathy Elzey daughter 2401 Canterbury Road, Cambridge, MD 21613 permit. Pages 1 and Department of Healt Important: If Item 2 any Injury or other ODCE. 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 1/24/09 Dorchester Memorial Pk Cambridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. Funeral Service Licenses 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner herosclerosts Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 2 No 1 TYes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

State Registrar 31. Date filed (Month

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			For	State of Marylan	•			Mental Hy	giene			
		•	State Registrar		C	ertificate of L	Death		Reg. No. 20	09	03	159
	Physici	an	1. Decedent's Name (First, Middle, Last)	0		. 1		2. Date of De Month	ath Day	Year	3. Time of I	
	/Medic	al	1) AVIL 2 A		455	4b. City, Town, or	Location of Doct	JAN	4c. County	of Dooth	162	<i>5</i> M
	Examin	er	4a. Facility Name (If not institution, give si	i Mad (74.	0	A RC L	4 45	4c. County	2-1A		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthda		If Under 24 Hrs. Hours Min.	_	th v Vearl	9. Birthpla	ace (State or	r Foreign
	Director		043-32-7609	M 2□ F 68	Yrs.	Wonth's Days	Hours Min.	8. Date of Bir (Month, Da AUGUST 3	1,1940		FORNL	A
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or	Location		-		10	d. Inside City	y Limits
	Maryl f sho	ţo	MARYLAND ANNE AF	RUNDEL	-	ANNA	POLIS				1 ∐Yes	2 X No
	h the	Directo	10e. Street and Number		 -	10f. Zip Code			10g. Citizen of W	√hat Countr	ry?	
	death with the Maryland	ra	1974 BALTIMORE ANNA	POLIS BOULEV	ARD		21409		UNIT	CED ST	CATES	
		Funeral	Tr. Maria Glado	 Was Decedent Ever in U. Armed Forces? 1 XYes 2 No 196 	S. 10	 Was Decedent of Hill If Yes, specify Cuba 	ispanic Origin? (S ın, Mexican, Pueri	Specify Yes or No to Rican, etc.)	14. Race Blac	e - Am <i>e</i> rica k, White, et		
36	hours after tural", or ite	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	If Voc Civo	984	1 □Yes 2 X No	Specify:		Specify	WHI!	ГE	
5-0036	2 hou	ted	15. Decedent's Educa	ation	16a. Dec	cedent's Usual Occupa	ation	dia.	16b. Kind of Bu	siness/Indu	ustry	
7	filed within 72 Hygiene. other than "nai ent, in "Mole	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life	ve kind of work done of DO NOT use retired,) -	rking				
7	e filed wi al Hygier other th vent, th			5+		TAIVA		(Prince herelet)	MILITAR		MERCL	<u>AL</u>
Maryland	be d d	Be	17. Father's Name (First, Middle, Last) JOHN J. RUSSELL					LEE FAV	. Maiden Surnam TNCER	е)		
Š	2 should be f and Mental I Is marked of aumatic eve	မ	19a. Informant's Name/Relationship (Typ	e. Print)	19b. Ma	iling Address (Street a				State Zin (Code)	
	nd 2 alth a alth a 27 ls		COLIN F. RUSSELL/SO		1974	BALTIMORE	ANNAPOI	LIS BOUL	EVARD, MA	NAPOL RYLAN	.TS ID 2140	09
altimore,			20a. Method of Disposition			position (Name of ematory or other place	e)	Date	20c. Location -	City or Tow	vn, State	
Ĕ	Pages ment of ant: If it ury or o	١.,	1 X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State ARI	METER	DN NATIONA Z		2009	ARLINGT	ON, V	IRGINI	A
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensed	/)		22. Name and Addres CREMATION ROAD, ANNA	ss of Facility FEI AND FUNE	LOWS HERAL CAR	ELFENBEI E. P.A	N AND 814	NEWN/ BESTG/	AM ATE
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E			23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final	cause on each line.	n. Do not e	757	-		riest,		Approximate Interval Betw Onset and D	veen
*	Physician /Medical		disease or condition resulting in death)	Due to (or as a conseq		14en	Hton	H		_		
	Examiner		1	Due to (or as a conseq	derice or).							
	T +	Je.	Sequentially list conditions, b. cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec			-					
	ecute and transi	Examine	Cause (Disease or injury that initiated events resulting in death) Last									
δύ,	be executed ician and burial-transit		resulting in death) East	Due to (or as a conseq	uence of):							
98/60	death certificate be executed e attending physician and id for use as the burial-transit	dical	d.									
ROX	leath certific attending p	M/N	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregna					23d. Dat	e of deliver	rv	
	death e atte	icia	in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 Feta		B ☐ Ectopic pregnancy □ Other (specify)	У		Moi			'ear
7. O	the by th	Physician/Me	9 🗆 Unknown	9 ☐ Unknown								
	requires that seen signed b	by	Part II. Other significant conditions cont	ributing to death but not res	ulting in the	underlying cause give	en in Part I.		obacco use contr			
Kecords,	requi	Completed						1 🗆 '	Yes 2 No	3∐ Proba	ably 4 U	nknown
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_	sician: The law certificate has b irector, page 2 sl		OF Man ages referred to modical					1 □ Yes	2 2 No 1	Yes 2	2 □ No	
=	rsicia s certi lirecto	o Be	25. Was case referred to medical examiner? 1 XYes 2 □ No	ospital: 1 X Înpatient 2 □	EB/Outpat	ient 3 DOA Othe	or.	ath <i>(Check only c</i>	<i>nne)</i> dence 6 ⊟Othe	or (Conside	1	
0	g Phy ter this neral c	n:To	27. Manner of Death	28a, Date of Injury	28b. Time	of 28c. Injury	y at		how injury occurre			
DIVISION	ath. or: Aff	atio	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Morth, Day, Year)			Yes 2 No	Fel	14 hit	he	Ad'	
<u>≥</u>	r Atterde	Certification:	Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm,	street, factory, office		28f. Location (:	Street and Number	er or Rural	Route Numb	ber,
	oital ours af urs af ural D		00.0.0.0	Home	-				apoli	511	127	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, it	Medical		ician: To the best of my known of the basis of examination and manner stated.								
	orthe	Mec	29b. Signature and title of certifier	2	0.4	29c. License	e number		29d. Date signed	(Month, D	lay, Year)	
b	XX	0	1/1/1/1/1	2000	put	200	6054		1/15	19		
	2400	-	30. Name and address of person who cor	npleted gause of death (Iter	n 23a) (Typ	e, Print)	-			k		
	. Was		William P.		20	1045	Ame	PICA	210	35		
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	1						
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2009 8:15 A M Rollins January 20, Herbert L. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Frederick Frederick 1000 Rosemont Ave. If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 XM 2 □ F Director 212-24-6076 80 15, 1928 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show in than "natural", or items 23a or 28a-f show Frederick 1 X Yes 2 □ No Director Maryland Frederick 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? United States 1000 Rosemont Ave. 21701 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No Korean IYes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 🔀 Married altimore, Maryland 21215-0036 than "natural", or 1 ∐Yes 2 TNo Specify. Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Judge Court Systems d 2 should be filed with and Mental Hygie 7 is marked other ti 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev Lester Rollins Irene Mann 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Betty Rollins / Wife 1000 Rosemont Ave., Frederick, MD 21701 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 1/22/2009 Frederick, Maryland Stauffer Crematory 21. Signatur of Funeral Service License 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702 own to 23a. eart). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on early line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 2.54 = -×6 115168 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): burial-transit and Due to (or as a consequence of) Box 68760, physician death certificate be Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) P.0. s been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 2 ANo 1 ☐ Yes 2 ☐ No 1 □Yes Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ≇ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) 2 no D146 2C 541 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21701 50 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 2 State of Maryland 12 Post of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Reynolds Ruth Garrett 11, 2009 8:40 PM January /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 104 Milestone Road Elkton Cecil If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 11/15/1929 Birthplace (State or Foreign Country) **Funeral** Months 212-26-0651 1 □ M 2 🏞 F 79 Director Delaware Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits ortant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at MD Cecil Elkton 1 ☐Yes 2X No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21921 104 Milestone Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Secretary Chemical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 is marked other any injury or other traumatic event. Be Herbert C. Garrett Ruth Moss 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 801 Locust Point Road, Elkton, MD 21921 William D. Trone / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Elkton Cemetery 01/14/2009 Elkton, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Family Funeral Home 635 Churchmans Road, Newark, DE 19702 Edward McKeown per DVR 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed and Due to (or as a consequence of): attending physician Physician/Medical the IF FEMALE: If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day ☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To Manner of Death
Natural
Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Hospital or Attending P 24 hours after death. Funeral Director: After t 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and

State Registrar

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Baltimore,

Vital

Division or

39, Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day АМ 5:48 **Physician** Myrtle E. Rice January 28, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Frederick Frederick Northampton Manor 8. Date of Birth (Month, Day, Year) November 30, 1906 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 ☐ M 2 🔀 F Yrs. Maryland 218-30-9138 102 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10b. County 10a. State d other than "natural", or items 23a or 28a-f show event, the "Modical Examinar must be notified at 1 ☑ Yes 2 ☐ No Frederick Director Maryland Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21701 United States 200 East Sixteenth Street Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: White Baltimore, Maryland 21215-0036 If Yes. Give ģ Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any injury or other traumatic event, the "Malic once. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emma Virginia Geesey Jacob Luther Haller, Jr. ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7623 Baltimore National Pike, Frederick, Maryland 21702 Fern R. Hugglestone / Daughter 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition January 31. 1

Burial 2 □ Cremation 3 □ Removal from State Frederick, Maryland Mount Olivet Cemetery 2009 4 Donation 5 DOther (Specify) 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 106 East Church Street, Frederick, Maryland 21701 21. Signature of Funeral Service M01433 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MONTHS MALIGNANT MELANOME **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No 5 Other (specify) P.O. I ned by the sidetached for 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physician: "within 24 hours after death."

To the Funeral Director: After this certifica 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner' Other: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1-29-09

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

September 1997

32. Registrar's Signature

September 1997

33. Date filed (Month, Day, Year)

34. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ronald Miller, M.D.

4 Culwell Drive, Mount Airy, Maryland 21771

		1	For Stete Registrar		State of	Marylan	-	rtmen tificat					g. No. UU	9	031	-
	Physicia		Decedent's Name (Find Daniel)		a	F	Ryan				2	2. Date of Death Month Jan 29		reer .	3. Time of 1210	Death
!	/Medic Examin		4a. Facility Name (If not	t institution, give	street and numb	oer)				Location o	f Death	0411 20	4c. County of		1210	
			Allegany (ehab C		Cu If Under	mbe	rland If Under 2	24 Hrs. 1	B. Date of Birth	Allega		ace (State o	or Foreian
	Funeral Director		219-14-64	141 10	XM 2□F	84	Yrs.	Months	Days	Hours	Min.	May 26	5,°1924	Coun	MD	
	yland low) H		b. County		10c. City	y, Town or Lo		nd					10	Od. Inside Ci	•
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	3a or 2	I Dire	10e. Street and Numbe 701 Furna		et			10f. Zip	Code	2150	2		-	SA	uy:	
936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 ie marked other than "natural", or items 23a or 28a-f ehow important: If item 27 ie marked other than "natural", or items 23a or 28a-f ehow appring right or other treumatic event, the Medical Examinat must be notified at once.	by Fur	11. Marital Status 1 ☐ Never Married 3 ☐ Widowed 4 ☐	_	12. Was Deced Armed Ford 1 Tyes 2 If Yes, Give Year or Dat	es? :□No \\\/\\/		Was Decedif Yes, specific		spanic Orig n, Mexican Specify:	gin? (Spec , Puerto R	ify Yes or No- ican, etc.)	14. Race Black Specify:	- America White, e	∍tc.	
2-0	72 ho	eted	15 (Specify o	. Decedent's Edu	cation e completed)		16a. Dece	dent's Usua kind of wo	al Occupa	ition furing most	of working	g	6b. Kind of Bus	iness/Ind	lustry	
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Mary	d 2 shorth and N 7 le material		19a. Informant's Name Christoph	er Ryan	rpe, Print)	n	19b. Maili 65 I	ng Address East O	ffutt S	ind Numbe treet	r or Rural	Route Number, Cumb	City or Town, S perland	tate, Zip M	Code) D 215	02
ore,	Pages 1 and nent of Health int: If Item 27 ary or other tr	-	20a. Method of Disposi	femation 3 □ F		0	lace of Disponenter, created arpelli F	matory or o	ther place	e, P.A.	Da	1/30/2009	Cresar			MD
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	ate be executed Wedical hysician and the burial-transit	al Examiner	23a Part Enter the canonic shock, or heart to shock, or heart to shock, or heart to shock of the shock	ions, idiate ng	a. Due to (o	r as a conseq	uence of):	ler the mod		g, such as	cardiac or	respiratory arre	est,		Approximat Interval Bet Onset and	ween
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S, D	requires that the been signed by th hould be detache	þ	Part II. Other significa	nt conditions co	ntributing to dea	ath but not res	ulting in the u	nderlying (cause give	en in Part I			acco use contri s 2 □ No	bute to th		death? Unknown
Vital Record	The la ate has page 2	Completed					110-110-110-110-110-110-110-110-110-110					24a. Was a autops perform	y pr ned? de	ere autorior to coreath?	psy findings inpletion of c	available ause of
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred examiner?		Hospital:				Oth	25		(Check only on				
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Division	l or Attending after death. Director: After	Certification:	2 Accident 3 Suicide 4 Homicide	investigation 6 Could not be determined	288. Place	of Injury - At h g, etc. (Special	ome, farm, st fy)					8f. Location (St City or Town	reet and Numbe , State)	r or Rura	l Route Nun	nber,
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			30. Name and address	GUPTO	A MI	D- 160	35 K	Port.	- A	E.	m	BERLA	M, Mr	7	150	X
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DHMH 17 Rev 1/2001

		-	For State Registrar	State of Maryla	cer	tificate of L	eaim and iv Death	ientai myg R	eg. No. 2009	9 03164
П	Physicia	an .	1. Decedent's Name (First, Middle, Last)					Date of Deat Month	Dav Year	3. Time of Death
	/Medic			ingirth		4h Olto Tanan an	Lacation of Dooth	January	7 18, 2009 4c. County of Dea	8:58 p M
	Examin	er	4a. Facility Name (If not institution, give sti 398 Deer Drive	eet and number)		Lusby	Location of Death		Calvert	ui
×***	Funeral		5. Social Security Number 6. Sex	7. Age (In y	rs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,		thplace (State or Foreign
	Director		217-34-2057	/ 2□F 7:	2 Yrs.	Months Days	Hours Min.	Dec. 23	L, 1936 Ma	aryland
	land bw		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Loc	cation				10d. Inside City Limits
	Mary -f sh	ţ	Maryland Calve	rt	Lusb	v				1 ☐ Yes 2 🛣 No
	h the	irec	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Co	ountry?
	death with the Maryland ims 23a or 28a-f show r. must be rediffed at	Funeral Director	398 Deer Drive			20657			USA	
	er dea	nne	11. Maritar Status	. Was Decedent Ever in Armed Forces?	13. V	Vas Decedent of Hi fYes, specify Cuba	ispanic Origin? (Spo n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
50	be filed within 72 hours after death with the Marylan tal Hygiene. d other than "natural", or Items 23a or 28a-f show event, It is Medical Examinar must be recitied at	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 No If Yes, Give Year or Dates:	1	□Yes 2XNo	Specify:		Specify:	White
3-003p	2 hou latura	ted	15. Decedent's Educa (Specify only highest grade)	tion	16a. Deced	lent's Usual Occup	ation Juring most of worki	na	16b. Kind of Business	/Industry
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7	e filed within al Hygiene. I other than " vent, II e Me		11 Table of a Name (First Middle 1 act)		Postal	Carrier	18. Mother's Name	(First Middle I	U.S. Posta	al Service
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Mary	permit. Pages 1 and 2 should be fo Department of Health and Mental I Important: If item 27 Is marked of any injury or other traumatic eve once.	2	19a. Informant's Name/Relationship (Type Elizabeth A. Spring	e. Print)			and Number or Rura		r, City or Town, State, 065 7	Zip Code)
e,	1 and Healt tem 2		20a. Method of Disposition			sition (Name of natory or other place		Date	20c. Location - City or	Town, State
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a	partm porta y Inju		21. Signature of Funeral Service Licenses		22 F	Name and Addres			Home Inc.	
מ	e e e e		alams & E	Jooley	5	00 Unive	rsity Blv	d., W,.	Silver Sp	ring,MD 20901
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one	ations that caused the d cause on each line.	eath. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
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	/Medical Examiner		Total and the second	Due to (or as e cons	sequence of):					
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			IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pre					23d. Date of de	elivery
). Box	death ce	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown		Ectopic pregnance Other (specify)	y 		Month	Day Year
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Ž	The law ate has b bage 2 sh	Completed						autops perfori	sy prior to med? death?	completion of cause of
VITa	an: T tificat tor, pe		25. Was case referred to medical				26. Place of Deat	1 ☐ Yes		s 2□No
	nystci nis cer direc	To Be	examiner? 1 ☐ Yes 2 ☑ No	spital: 1 ☐ Inpatient 2	2 🗌 ER/Outpatien	nt 3 DOA Oth	or:		ence 6 ☐ Other (Spi	ecify)
Division of	After th	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Yea	28b. Time of Injury	Worl	ί?	28d. Describe ho	ow injury occurred	
<u> </u>	death ctor: y the I	ficat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - A	At home, farm, stre		Yes 2 □No	28f. Location (S	treet and Number or F	tural Route Number,
2	al or A after I Direct	Certification:	4 ☐ Homicide determined	building, etc. (Sp	ecify)	,	1	City or Town	n, State)	
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s	Medical C	29a. Certifier (Check only one) 1X Certifying Physical Examination (Check only one)	cian: To the best of my er: On the basis of exar and manner stated.	knowledge, death mination and/or in	h occurred at the til vestigation, in my c	me, date and place, pinion, death occur	and due to the or red at the time, or	cause(s) and manner a date and place, and du	as stated. e to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	- /		29c. Licens		I .	29d. Date signed (Mon	
	5						D3696	9 .	January 19	, 2009
			30. Name and address of person who cor Scaria Mathew, M			Print) Lusby, M	D 20657			
	Sta Registr		31. Date filed (Month, Day, Year) JAN 20 2009	32 Registrar's S	In-ad-us					
					7					

		State of Maryland / Department of He 1 - State Registrar Certificate of De	alth and M eath	ental Hygie Reg	ne 200	9 03165
Physic	ian	1. Decedent's Name (First, Middle, Last)				3. Time of Death
/Medi	cal	Anna Slamen 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Lo	ocation of Death	January	Day Year 18, 20	09 8:12 a ^M
Exami	ner	Montgomery General Hospital Olney			Montgom	
Funeral Director		5. Social Security Number 217-42-4426 6. Sex 1 M 2 F R 80 Yrs. T. Age (In yrs. last birthday) If Under 1 Year II Months Days Months Days T. Age (In yrs. last birthday) If Under 1 Year II Months Days Months Days T. Age (In yrs. last birthday) If Under 1 Year II Months Days Months Days T. Age (In yrs. last birthday) If Under 1 Year II Months Days Months Days T. Age (In yrs. last birthday) If Under 1 Year II Months Days T. Age (In yrs. last birthday) If Under 1 Year II Months Days T. Age (In yrs. last birthday) If Under 1 Year II Months Days T. Age (In yrs. last birthday) If Under 1 Year II Months Days T. Age (In yrs. last birthday) If Under 1 Year II Months Days T. Age (In yrs. last birthday) If Under 1 Year II Months Days T. Age (In yrs. last birthday) If Under 1 Year II Months Days T. Age (In yrs. last birthday) If Under 1 Year II Months Days T. Age (In yrs. last birthday) If Under 1 Year II Months Days T. Age (In yrs. last birthday) If Under 1 Year II Months Days T. Age (In yrs. last birthday) If Under 1 Year II Months Days T. Age (In yrs. last birthday) If Under 1 Year II Months Days T. Age (In yrs. last birthday) If Under 1 Year II Months Days T. Age (In yrs. last birthday) If Under 1 Year II Months T. Age (In yrs. last birthday) If Under 1 Year II Months T. Age (In yrs. last birthday) If Under 1 Year II Months T. Age (In yrs. last birthday) If Under 1 Year II Months T. Age (In yrs. last birthday) If Under 1 Year II Months II	Hours Min.	8. Date of Birth (Month, Day, You April 19	9. Bir 9, 1928	thplace (State or Foreign ountry) Hungary
and		Usual Residence of Decedent 10a. State				10d. Inside City Limits
Maryl a-f sho	tor	Maryland Montgomery Silver Spring				1 ☐ Yes 2X No
or 28g	Director	10e. Street and Number 10f. Zip Code	906	10g	. Citizen of What C	ountry?
if e), INIAT yIATIO ZIZIO-0030 s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Mydical Exaction or countries.	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hisp Armed Forces? 15 Yes, specify Culan.		cify Yes or No- Rican, etc.)	14. Race - Am Black, Whit	
hours aft	by	31 → Widowed 4 □ Divorced Year or Dates:	Specify:	40	Specify:	White
vithin 72 me.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired)	ring most of workin	ng 16	b. Kind of Business	·
filed w Hygie other t	Be Co	9 Business (17. Father's Name (<i>First, Middle, Last</i>)	8. Mother's Name			h Shop
ylan	To B	Nandor Maurer	Maria	a Schneid	der	
nd 2 sho alth and 27 is m		19a. Informant's Name/Relationship (Type. Print) Angela M. Sanders/ Daughter 19b. Mailing Address (Street and P.O. Box 473)			-	
Daltillore, Ma permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery.	etery Ja	an. 22,	c. Location - City or	
Dalkillion permit. Pages Department of Important: If it any injury or once.		21. Signature of Funeral Service Licensee 22. Name and Address Francis J.	of Facility Collins	Funeral 1	Home Inc.	ing, Maryland ing, MD 2090
		23a. Part1. Energy the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line.				Approximate Interval Between
Physician /Medical		In the Park Court (Effect)	Deforti	čen.		Onset and Death
Examiner		Due to (or as a consequence of):	Para top la	direase		Yen
ted nsit	Examiner	If any, leading to immediate cause. Enter Underlying Cause. Enter Underlying Cause (Disease or injury				
execu an and rial-trar		that initiated events c				
icate by	edical	d				
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ 9 □ Unknown			23d. Date of de Month	elivery Day Year
that th		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given it	in Part I.	23e. Did tobac	co use contribute t	o the cause of death?
equires een sig ould be	ted by			1 □ Yes	2 □ No 3 □ P	robably 4 Unknown
The law rate has be page 2 shu	Completed			24a. Was an autopsy performed 1 ☐ Yes 2 ☑	prior to death?	utopsy findings available completion of cause of
VILC siclan: certific rector,	Be	examiner?	6. Place of Death	(Check only one)		
g Physicer this	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	4 LI Nursing Horr	ne 5 Residence 8d. Describe how	e 6 ☐ Other (Speniury occurred	ecify)
tendin leath. tor: Aff	catio	3 Suiside 6 Could not be	s 2□No			
ital or Al	Certification:	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		City or Town, S		ural Route Number,
he Hosp in 24 hou he Funer pletely fil	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, check only and manner stated.				
	Σ	29b. Signature and title of certifier 29c. License no			Date signed (Mon	th, Day, Year)
30		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stor Print Stor Pri	· · · · · ·	Olhe.	20632	
Sta	ate	31. Date filed (Month, Day, Year) 32 Registrar's Signature	ing sty	O's	20152	
Regist	rar	JAN 21 2009 Ceture B. Jakes				

Physician /Medical

Examiner

Directo

Be Completed by Funeral

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Examiner

Medical Certification: To Be Completed by Physician/Medical

Funeral

	pe or Print in E					•	_	ble.	
For State Registrar	State of Marylan		rtificate of		a ivie		ene ı. №.2 N	nα	03166
1. Decedent's Name (First, Middle, Last)	CUA:	055				. Date of Death			3. Time of Death
4a. Facility Name (If not institution, give str	Esther SHAL	UFF	4b. City, Town, o	or Location of De	_	January	4c. County		4:25 A M
Holy Cross Hospita 5. Social Security Number 6. Sex		(act hirthday)	Silver If Under 1 Year	Spring	dre Lo	Date of Birth		gomer	
	7. Age (In yrs.)	Yrs.	Months Days		lin. S	Date of Birth (Month, Day)	1947	Hunga	ce (State or Foreig. v) ary
10a. State 10b. County	10c. Cit	y, Town or Lo	cation					10d	I. Inside City Limits
Maryland Montgom	ery	Silv	er Sprin	g		100	. Citizen of W	That County	1 □Yes 2 No
11407 Fairoak Drive			10f. Zip Code	20902			United		
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Vas Decedent of fYes, specify Cub I ☐ Yes 2 No		(Speci uerto Ri	fy Yes or No- can, etc.)		e - American k, White, etc Whi	
15. Decedent's Educat (Specify only highest grade of	tion completed)	16a. Deced	dent's Usual Occu kind of work done OO NOT use retire	pation during most of v	working	16	ib. Kind of Bu	siness/Indus	stry
Elementary/Secondary (0-12)	College (1-4or 5+)	1	avel Age				Agenc	:y	
17. Father's Name (First, Middle, Last) Josef Heb				1		First, Middle, Ma 1a Soos	iden Surnam	e)	
19a. Informant's Name/Relationship (Type Stanley Shaloff, Hu	. Print)	19b. Mailir	g Address (Stree Fairoak	t and Number or	Rural I	Route Number, (City or Town,	State, Zip C	ode) 902
20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Rer	20b. F	lace of Dispo cemetery, cren	sition (Name of natory or other pla morial G	ace)	Dat	te 20	Oc. Location -	City or Town	n, State
21. Signature of Fune at Service Licensee 23a. Part Effer the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d. d.	attions that caused the deatt cause on each line. Acute Massi Due to (or as a conseq Sepsis Out to (or as a conseq Respiratory Due to (or as a conseq	h. Do not ent ve Rig uence of): verce of): Failu	ht Hemis	1 St., I ing, such as card	N₩. diac or i	Washing respiratory arres	ton. D	l A	012 opproximate nterval Between Onset and Death
IF FEMALE: 23b. Was decedent pregnant in the past 1a months? 1 \(\triangle	c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown	Ideath 3	Ectopic pregnan Other (specify)	су			23d. Dat Mo	e of delivery	ay Year
Part II. Other significant conditions contri	ibuting to death but not res	ulting in the u	nderlying cause gi	iven in Part I.			V		cause of death?
25. Was case referred to medical				00 Bloom		24a. Was an autopsy performe 1 Tes 24	ad? 5 DNo 1	Were autops prior to comp death? I □ Yes 2	y findings available pletion of cause of
examiner? Value Host 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	spital: 11 Inpatient 2 Inpatie	ER/Outpatier 28b. Time of Injury	28c. Inju	her: 4 🗆 Nursin	g Home	e 5 Residen	ce 6 ☐ Oth		
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. <i>(Specit</i>	ome, farm, str fy)	eet, factory, office		28	f. Location (Stre City or Town,	et and Numb State)	er or Rural F	Route Number,
29a. Certifier (Check only one) 1 Certifying Physic 2 Medical Examine	cian: To the best of my known: On the basis of examination and manner stated.	owledge, deat ation and/or in	h occurred at the vestigation, in my	time, date and pl opinion, death o	lace, ar	nd due to the car d at the time, dat	use(s) and ma e and place, a	anner as sta and due to th	ted. he cause(s)
29b. Signature and title of certifier	Rohmo	livei	29c. Licen D 66	nse number 5372		290	d. Date signed	d (Month, Da 109	ay, Year)
30. Name and address of person who com Majid Rahmanianshar	i, M.D., 150	00 Fore		Road, S	ilv	er Spri	ng, MD	2091	0
31. Date filed (Month, Day, Year) JAN 21 2009	32 Registrar's Signa	A. Jac	Med.						

State Registrar

10

Amend #17,per FD, 1/26/09,CCHD,drw

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1		partment of Health and N ertificate of Death		0000	00167								
			1. Decedent's Name (First, Middle, Last)	erimoate or Death	2. Date of Deat	eg. No. 2009	3. Time of Death								
	Physicia	an	Joyce Hudson Strahorn		Month January	Day Year 16, 2009	6:00 A M								
Sales.	/Medic Examin	- 4	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	U.00 A								
	- ZAGIIIII	٠.	Calvert Memorial Hospital	Prince Frederic		Calvert									
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Months Davs Hours Min.	8. Date of Birth (Month, Day,	, Year) Cour	**								
l.	Director		229-50-9483 69 Usual Residence of Decedent		March 6	, 1939 Vi	rginia								
	yland sow		10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits								
	e Mar ta-f st	ctor	MD Anne Arundel Co. Lothia				1 □Yes 2X No								
	or 28	Director	10e. Street and Number	10f. Zip Code		0g. Citizen of What Cou	ntry?								
	s 23a	eral	9 Patuxent Mobile Estate 11 Marital Status 12. Was Decedent Ever in U.S. 1	20711 3. Was Decedent of Hispanic Origin? (Sinf Yes, specify Cuban, Mexican, Puert		U.S.A. 14. Race - Americ									
36	be filed within 72 hours after death with the Maryland tal Hyglene. Ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ▼ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in O.S. Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puèrt 1 ☐ Yes 2 No Specify:	o Rićan, etc.)	Black, White, Specify: Wh	ite								
21215-0036	72 hor	Completed	(Specify only highest grade completed) (G	cedent's Usual Occupation ive kind of work done during most of work	king	16b. Kind of Business/In	dustry								
21	within ene. than "	ם	Elementary/Secondary (0-12) College (1-4or 5+)	e. DO NOT use retired)		Real Estate	Commonser								
	filed v Hygie other t		12 +2 Sec	retary/Bookkeeper 18. Mother's Nan		Neal EState Maiden Surname)	Сопрану								
an	should be and Mental some marked o	To Be	Marion Marzelle Strahern Hudson	Mable	Poole										
ary	2 should be and Menta Is marked a		19a. Informant's Name/Relationship (Type. Print) 19b. M	ailing Address (Street and Number or Ru	ıral Route Numbe	r, City or Town, State, Zi	o Code)								
Baltimore, Maryland	5 5 5 5		Linda W. Doss (Friend/POA) 68	Patuxent Mobile Es	tate, Io	thian, Mary	land 20711								
ore	iges 1 ar nt of Hea if Item or other		1 Burial 2 Li Cremation 3 Li Hemoval from State		uary 20,		,								
Itim	it. Pa intmer intant: njury		4 Donation 5 Other (Specify) 21. Signature of Edge Celebrase	Branch Ch. Cem. 29 22. Name and Address of Facility L		Wythe Count al Home Cal									
Ba	permit. Pages 'Department of the Important: If Ite any Injury or of once.		W. Jee	8125 Southern Mary	land Blv	d., Owings,	MD 20736								
			shock, or heart failure. List only one cause on each line.	Office and Death											
	Physician /Medical			bstructive H	irway	direase									
	Examiner		Due to (or as a consequence of):												
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury												
	scuted nd transit	Examiner	that initiated events c												
8760,	tate be executed obysician and the burial-transit		resulting in death) Last Due to (or as a consequence of)												
687	ficate physi s the l	edical	d												
P.O. Box (The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 18 No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delive Month	very Day Year								
Q .	ires that the de signed by the a be detached t		Part II. Other significant conditions contributing to death but not resulting in the			bacco use contribute to									
ords	w require been sig should b	ed b	Atheroscienotic Cardiov	cocular dixax	1 🖭 🖰	res 2□ No 3□ Pro	bably 4 Unknown								
or Vital Records,	sician: The law r. certificate has be irector, page 2 sh	Completed by	Diahetes mellitus		24a. Was a autop perfor	prior to c rmed3 death?	opsy findings available ompletion of cause of 2□ No								
Vita	Physician: this certificantal director, I	Be	25. Was case referred to medical examiner? Hospital:	Othor	ath Check onl o		w.)								
or	this d	 1	27. Manner of Death 28a. Date of Injury 28b. Tin	ne of 28c. Injury at	T	dence 6 Other (Spec now injury occurred	ity)								
on	nding th. r: Afte e fune	tion	1 ☑ Natural 5 ☐ Pending (Month, Day Year) Inju	M 1 ☐ Yes 2 ☐ No											
Division	al or Atters after dea	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury · At home, farm building, etc. (Specify)	ı, street, factory, office	28f. Location (S City or Tox	Street and Number or Ru vn, State)	ral Route Number,								
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and/and manner stated.	or investigation, in my opinion, death occ	curred at the time,	date and place, and due	to the cause(s)								
	To t withi To t	Ž	29b. Signature and title of certifier Eya. C. Surana.	29c. License number D . 50653	3	29d. Date signed (<i>Montt</i>									
d	RW 10		30. Name and address of person who completed cause of death (Item 23a) (To 5851 - Deale Church)	on Road F	Juna N Zeale	MD 20	75/								
	St Regist	ate trar	31. Date filed (Month, Day, Year) 32. Registraris Signature JAN 2 1 2009 Denoma	G. Sarke											

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Thomas C. Sollers 2009 2050 Jan. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Annapolis
If Under 1 Year | If Under Anne Arundel Medical Center Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M M 2 □ F 30 1953 Maryland June_ Director 55 213-64-1590 Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City, Town or Location the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a five lice Examiner must be notified at once. 10a State 1 √Yes 2 No Director Annapolis Maryland Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21403 9 d Marcs Court Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Never Married 2 Married 1 □ Yes 2 □ No If Yes, Give Year or Dates: 1972-74 1 ☐ Yes 211 No Specify: Black Baltimore, Maryland 21215-0036 Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sand & Grave1 Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Smith Charles Sollers ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20784 19a. Informant's Name/Relationship (Type. Print) Hyattsville,Md 3406 55th Ave. Apt.204 <u> Clarence Sollers (Brother)</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition p☐Burial 2 ☐ Cremation 3 ☐ Removal from State 1/23/09 4 Donation 5 Other (Specify) Maryland Veteran Crownsville, Md. 22. Name and Address of Facility 821 West St. Annapolis, 21. Signature of Funeral Service Licenses 21401 Wm. Reese & Sons MOrtuary, P.A. Jarry G. Leese MO0483 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final tastatic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Atheresclostic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown cate has been signed by page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2.☒No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1) Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of funeral 27. Manner of Death 28c. Injury at Work? After t 1 Natural 5 Pending investigation 1 □Yes 2 □ No death. 2 Accident within 24 hours after deatl To the Funeral Director: 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide á 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2001 29nche 31. Date filed (Month, Day, Year) JAN 2 0 2009 32/Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 🕕 🖰 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Dorothy E. Smith 7:25 AM 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 24 Hrs. Micomico at th Lak Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 203 F Months Hours Min. 219-16-1889 82 Director 4/11/1926 MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Modical Examinating the inclinion at MD Wicomico Director Salisbury 1 ☐ Yes XXNo 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 334 Troopers Way Funeral 21804 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 図域o 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: White ğ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be s 1 and 2 should be fil f Health and Mental H item 27 is marked otl Edward S. Britton Rose Lamb 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellsworth Smith Jr. Spouse 334 Troopers Way Salisbury, MD 21804 permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State transparent to the transparent of the transparent to the transparent 4 Donation 5 Other (Specify) Hillcrest Mem Gardens 1/15/2009 Annapolis, MD 21401 21. Signature of Funeral Service 21 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, Md 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** TAUR RANAL disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician; The law requires that the death certificate be executed the outs after death. and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Pregnant at time of death 5 Other (specify) the 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed this certificate 2 No 1 ☐ Yes 2 No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1∐Yes 2⊿No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other (Specify) HOSPICK 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after deat To the Funeral Director; 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ca 29a. Certifier completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 20058410

State Registrar 6 Humm

31. Date filed (Month, Day, Year)

HOSPICE P. SOR 1733 SANG BUNY WO 21802

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

WAMI

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th and Mental Hyg	iene UUJ	UJ	110

State of Maryland / Department of Heal Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Eleanor V. Stansbury January 2009 2:10 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel 1413 Foxwood Ct. Annapolis If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** ^{Year)}927 Months Days Mar 16 Min. 1 ☐ M 2 7 F Maryland 219-30-9495 81 Yrs Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at 1X Yes 2 No Marvland Anne Arundel Annapolis Director death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural", or Items 23a or dical Examiner must be r 1413 Foxwood Ct. 21401 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after of health and Mertal Hygiene. It It is the 27 is marked other than "natural", or liter any or other traumatic event, the Medical Examiner any or other traumatic event, the Medical Examiner. 1 Yes 2 Notes:
If Yes, Give
Year or Dates: 2[XNo 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Clerical State of Maryland O 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ridgley Johnson Beulah Stansbury 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn Darden(Niece) 2606 Glencoe Circle Woodstock, Md. 21163 20a. Method of Disposition Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of I Important: If Its any Injury or o once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veteran 1-12-09 Crownsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) Wmame Recesse of Secilis ons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 Tarry G. Reen MO048 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIAC **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed physician and the burial-transi Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: nse s 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? for Month Year 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not result ting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Thoged 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ♣ No demic 24a. Was an has page 2 autopsy performed 2 No Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA after death.

Il Director: After this of d in by the funeral director. Other: 1 Yes 2 No Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide filled i within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely and manner stated. the ೭ Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar 09-00550 Lori A. Shipley

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ri A. Shipley	State of Maryland / Department of H 1- For State Certificate of D Registrar	lealth and Mental Hy Death	/giene 2009 031					
Physician ledical Examine	1. Decedent's Name (First, Middle,Last)	2. Date of Death Month Day January 19, 2009 3. Time of Death 1234 hrs						
	4a. Facility Name (if not institution, give street and number) 4b.	City, Town, or Location of Death Hagerstown	4c. County of Death Washington					
Funeral Director		If Under 1 Year If Under 24Hrs. Months Days Hours Min.	Country					
w any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits					
the Maryland a or 28a-f show any lifted at once.	Maryland Frederick Frederick 10e. Street and Number	0f. Zip Code	10g. Citizen of What Country?					
er death with	11. Marital Status 1 Never Married 2 X Married 1 Never Married 2 X Married 1 Yes 2 X No 2 Wildowed 4 Diverged If Yes Give Year	21701 Decedent of Hispanic Origin? (Sp. specify Cuban, Mexican, Puerto						
5-0036 ed within 72 hours after lygiene. other than "natural" he Medical Examine	or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's	Usual Occupation (Give kind of very of working life, DO NOT use retired to the control of the co	work done 16b. Kind of Business/Industry red)					
21215-0036 July be filed within 72 Mantal Hygiene. marked other than 'c event, the Medical		r of Human Reso 18.Mother's Name Mildred	e (First, Middle, Maiden Surname)					
MD 212 d 2 should be the and Ment m 27 is mark aumatic ever	19a. Informant's Name/Relationship (Type, Print) Gregory Shipley/ Husband 1497 Edition	ddress (Street and Number or F den Drive, Fred	Rural Route Number, City or Town, State, Zip Code) Lerick, Maryland 21701					
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed withi Department of Health and Mental Hygiene. Important: If tien 27 is marked other it injury or other trannatic event, the Med	20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donatiop 5 Other Specify: 20b. Place of Disposition crematory or other Stauffer C	on (Name of cemetery, place) rematory Inc.1/	Date 20c. Location - City or Town, State /21/09 Frederick, Maryland					
Balt Depart Imbor	21. Signature of Funeral Service Licensee 22. Nar Star 162 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the	ne and Address of Facility uffer Funeral H 1 Opossumtown P mode of dying, such as cardiac o	respiratory arrest, shock, or heart Approximate Interven					
/Medical caminer	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of):		Between Onset and Death					
ed	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):							
be executed ician and irial - trans	d. UNPENDED AMENDED							
n of Vital Records, P.O. Box 68760, ding Physician: The law requires that the death certificate be executed . After this certificate has been signed by the attending physician and finneral director, page 2 should be detached for use as the burial - transit	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 1 Yes 2 No 9 ✓ Unknown 9 Unknown							
S 50 6		derlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ✔ No 3 ☐ Probably 4 ☐ Unknown					
Records, The law requir			24a. Was an autopsy findings availab prior to completion of cause of death? 1 ✓ Yes 2 No 124b. Were autopsy findings availab prior to completion of cause of death? 1 ✓ Yes 2 No					
of Vital Recing Physician: The Affer this certificate uneral director, page	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient		ng Home 5 Residence 6 Other: Scene					
Division of Vital Records, tal or Attending Physician: The law requin rs after death. al Director: After this certificate has been s' led in by the funeral director, page 2 should the funeral director, page 2 should the	27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 4 Homicide 28a. Date of Injury Jan 19, 2009 and 1215 hrs 28b. Place of Injury Jan 19, 2009 and 1215 hrs 28c. Place of Injury - At home, farm, street, (Specify) Interstate/Express	Oriver auto auto collision 28f. Location (Street and Number or Rural Route Number, City or Town, State) VB I-70 @ mile marker 36, Hagerstown, MD						
hou hou	29a. Certifier Check only one) 2 Medical Examiner: On the best of my knowledge, death occurre one) 2 Medical Examiner: On the basis of examination and/or investigation	ed at the time, date and place, and	d due to the cause(s) and manner as stated.					
To with To Con	and manner stated. 29b. Signature and title of certifier Addlar	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) January 20, 2009					
(5)		treet, Baltimore, MD 2120	01					
Sta	31. Date filed (Month, Day Year) 32. Registrar's Signature	Extra						

09-0 Benj

0346 jamin Smith	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1 1 2 1 3							<u> </u>			
	Re	-inten	2. Date of De			Year Year	3-Time of Death 0921 hrs				
Physiciaı d∹∽⁻' Examin	Benjamin Gregory Smith January 12, 2009										
CAGIIIII	4a, Facility Name (if not institution, give street and number)					4b. City, Town, or Location of Death 4c. County of Death Montgomery					
		3405 Fredale Drive			Wheaton		8 Date of Birth (MM/DD/YYYY) g. B			
Funeral	5	. Social Security Number	6. Sex 7. A	ge (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24Hrs. Hours Min.	1	Fore	eign Privucky		
Director	1	217-21-1315	1 X M 2 F	36 Y	rs.		11/14	/19/2 Ke	eneucky		
v any	_	Jsual Residence of Decedent Oa. State MD 10b. County Mont	gomery	10c. City, Town or Loc			44		10d. Inside City Limits 1 X Yes 2 No		
rith the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number 3405 Freda	10f. Zip Code 20902			Citizen of What Co	ountry?				
D 21215-0036 should be filed within 72 hours after death with the Maryland and Montal Hygiene. T is marked other than "natural", or items 13a or 28a-f she ratic event, the Medical Examiner must be notified at once	- 4	11. Marital Status 1 X Never Married 2	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, White, etc.								
r deat	리		1 Yes		Yes 2 X No			Speeny.			
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after ment of Health and Mondal Bygiene. matter friem 27 is marked other than "natural", and then traumatic event, the Medical Examines or other traumatic event, the Medical Examines.	Completed by		15. Decedent's Education (Specify only highest grade completed) 16a. Decedenting					16b. Kind of Business/Industry			
36 hin 72 e. than	힐		1	sal	esman	18.Mother's Name	/First Middle M				
5-0036 iled within 7. Hygiene. d other than	S	17. Father's Name (First, Midd		Marg	aret Si	mpson					
D 21215-003 should be filed within and Mental Hygiene. 77 is marked other that natic event, the Med	Be	Bill G. Smi	iling Address (Street	tate, Zip Code)							
MD 2 td 2 shoul tlth and M m 27 is m aumatic	ျှ	Margaret Si	mpson (Mot				Date	20c. Location - Cit	wn, MD21769		
or Health of Hitem 2		20a. Method of Disposition 1	ion 3 Removal from	20b. Place of Discrematory of Smithsh	position (Name of ce r other place) ourg Crei	natory1					
Baltimore, permit Pages 1 at Department of Hee Important: If ite injury or other tr		4 Donation 5 Ther 2 Signature of Funeral Serv	Specify:		27 Name and Addres	B of Facility Om	pson Fu	neral H	Iome		
Balti permit Departm Imports	\	A1 lov -1 ///	WALL.	i i	$D \cap D = 1 \Omega$	Middla	town. N	11) 2.1709	Approximate Interval		
Physician		28a. Part I. Enter the disease,	ise of each mic.			g, such as curdicio			Between Onset and Death		
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		Immediate Cause (Final disea or condition resulting in death	_{ase a Heroin}	intoxicatio:	n						
		Sequentially list conditions,	b				N	1 131			
	ner	if any, leading to immediate cause. Enter Underlying Cau		consequence of):							
	Examin	(Disease or injury that initiate events resulting in death) La	ed	consequence of):							
760, ficate be executed g physician and s the burial - transit		T INDENDED	d	23a,27,28a-	f, perME,	g888 2/6	5/09 TT				
O, the ex sician	ed	X UNPENDED		utcome of pregnancy				23d. Date of de			
Box 68760, e death certificate be the attending physic	\ \S	IF FEMALE: 23b. Was decedent pregnant past 12 months?	in the 1. Live bi	rth 2	retai death	3 Ectopic preg	nancy	Month	Day Year		
ox 687 eath certific	icia	1 Yes 2 No 9		ant at time of death 5	Other (Specify)						
Bo le deal											
b.O. that the ned by											
S, F quires en sig	24a. Was an autopsy findings prior to completion of or death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No 26. Place of Death (Check only one)							ior to completion of cause of			
ord aw rec	4	<u> </u>					perf 1 ✓ Yes	Jimes.	eath? ✓ Yes 2 No		
Rec The I	5 Page	26.Place of Death (Check only one)									
ciam:	lection a	examiner?	Hospital:	Inpatient 2 ER/Out	patient 3 DOA	Other Nu	rsing Home 5	Residence 6			
Physic rerthis	eral di	27 Manner of Death	1 Ves 2 No 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred								
Sion C ttending death. ctor: Af	(Month, Day, Year) The second of the second								er or Rural Route Number, City		
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the ras after death.	Pending Investigation 2 Accident 3 Suicide 4 Scould not be determined 5 Pending Investigation 5 Pending 12 Accident 5 Pending 12 Accident 6 Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, or Town, State) 3405 Fredale Dr Gaithersburg, MD								Fredale Dr MD		
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:	26. Place of Death (Check only one) 26. Place of Death (Check only one) 26. Place of Death (Check only one) 27. Was case referred to medical examiner? 1 Ves 2 No 28a. Date of Injury (Month, Day, Year) 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Ves 2 X No 28f. Location (Street and Number or Rural Route Num or Town) 28f. Location (Street and Number or Rural Route Num or Town								as stated.		
the I	mplet	one) 2 Medica	al Examiner: On the basis and manner	of examination and/or in	vestigation, in my opi	cense number			ed (Month, Day, Year)		
F W F	3	29b. Signature and title of	certifier			.C.M.E.		January 13	, 2009		
		tarile	- 18lls	,							
		30. Name and address of p	person who completed car Pollak MD Assis	use of death (Item 23a) tant Medical Exami	iner 111 Penr	n Street, Baltir	nore, MD 212	201			

DHMH 17 Rev 1/2001 OCME 2006

State 31. Date filed (Month, Day, Year)
Registrar FFB U 4 2009

ORIGINAL

Months

10a. State

Social Security Number

447-36--1263 Usual Residence of Decedent

1. Decedent's Name (First, Middle, Last)

Gigi Josephine

6. Sex

1□ M 2₺ F

Southern Maryland Hospital

4a. Facility Name (If not institution, give street and number)

10b. County

Thomas

Age (In yrs. last birthday)

68

Yrs.

10c. City, Town or Location

4b. City, Town, or Location of Death

Clinton

If Under 1 Year | If Under 24 Hrs.

Days

Hours

2. Date of Death

January

8. Date of Birth (Month, Day, July 17

State of Maryland / Department of Health and Mental Hygiene

20°40

Birthplace (State or Foreign Country)

10d. Inside City Limits

Onset and Death

9

0

1 ☐ Yes 2 No

California

Black

2009

Prince George's

4c. County of Death

,1940

Box 68760, P.O. Records,

event, the Medical Examiner must be notified at Prince George's Brandywine 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 1 and yilury or other traumatic event, the Medical Examination once. 20613 U.S.A. 16920 Croom Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐Yes 2 XNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 🖾 No Specify: ò Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker-Poet Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Locomiss Gilford Ruby Rowland 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fred I. Thomas (Husband) 16920 Croom Rd. Brandywine, Md. 20613 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Chambers Crematory Jan.19,2009 Riverdale, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chambers Funeral Home & Crematorium, P.A. 5801 Cleveland Ave. Riverdale, Md. 20737 21. Signature of Funeral Service License Momos 5. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) End **Physician** /Medical Due to (or as a consequence of): Examiner 1 a 1 an Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Respirator or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 € Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 No 1∐Yes 2∐No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c, Injury at Work? 28d. Describe how injury occurred 1X Natural 5 Pending To the Hospital or Attend! within 24 hours after death. To the Funeral Director; A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifie 🖒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D-0064055 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) McDonald, M.D. 7503 Surratts Rd. Clinton, Md. 20735 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 21 Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

/Medical Examiner **Funeral**

Physician

Director show Director 28a-f

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 14, A^{M} January Martha Talbott. 2009 8:05 Ann C. 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Burtonsville Sanctuary at Holy Cross Montgomery 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 1□M 2ਊF 85 Washington, D.C May 15, 1923 220-26-2596 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 1 Yes 2 No Bowie Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 12207 Marne Lane 20715 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2X No 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Prince George's College (1-4or 5+) Elementary/Secondary (0-12) High School Teacher 5+ <u>County Schools</u> 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Harold F. Cotterman Mae Yingling 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Richard R. Talbott/Son 12207 Marne Lane Bowie, Maryland 20715 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 1/23/2009 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ce see 22. Name and Address of Facility Beall Funeral Home Bowie, MD 20715 6512 NW Crain Hwy. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atteroscherote Carolio varentas disease or condition resulting in death) Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE:

Priysician /Medical Examiner

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by the attending physician

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To the Hospitel or Attending Physicien:

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The law requiras that the death cartificate be exacuted

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

10a. State

MD

Funeral Director

Be Completed by

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Examiner

by Physician/Medical

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Certification:

Medicai

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar must be usuffiled at once.

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

9 Unknown

in the past 12 months?
1 Yes 2 No

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Melletus

9☐ Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

Year

23e. Did tobacco use contribute to the cause of death?

24a. Was an autopsy performed

1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify)

25. Was case referred to medical examiner? 1 ☐ Yes 2 🗙 No 27. Manner of Death

5 Pending

28a. Date of Injury (Month, Day Year) investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

MD

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 29b. Signature ar

1 Natural 2 Accident

3 Suicide

4 🗌 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

DO052861

29d. Date signed (Month, Day, Year)

2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AVENUE, SILVER SPRING GEORGIA 9801 ASHA VALI

velo

31. Date filed (Month, Day, Year)
JAN 2 0 2009

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** ELSET 1300 01 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Anne Arundel Medical Center Arunde 1
9. Birthplace (State or Foreign Country) Annapolis
Year | If Under 24 Hrs Anne Date of Birth (80/th 97/1942 If Under 1 Social Security Number Age (In yrs. last birthday **Funeral** Months Days Hours Min 1 □ M 2 🗷 F 214-40-0812 66 Director PA Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☐ No MD Anne Arundel Crownsville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 69 Summerhill Park by Funeral 21032 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ∐Yes 20 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2☐No Specify White 3 Widowed XX Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: if Item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Sales</u> Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Henry Helsel ပ Ruth Dishong 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health a
Important: if Item 27 is
any injury or other trau Brenda Hall Daughter 1184 Southview DR. Annapolis, MD 21409 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Cemetery: 1/19/2009 | Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. J 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospitai or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1/Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 ☐Yes 2 No 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's 2/ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Certification: To Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu A□ Accident investigation 1 ☐ Yes 2 No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) Signature and title of certifie

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #8 Per State of Maryland Department of Health and Mental Hygiene 2009

Certificate of Death

DHMH 17 Rev 1/2001

State Registrar Name and address of

Year

31. Date filed (Month, Date

who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Dav **Physician** 7:30 PM KATHRYN JANUARY SASSE THOMPSON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 8. Date of Birth Dec 10, 9. Birthplace (State or Foreign Country) New York If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months Hours 1 □ M 2 🗗 F 216-20-9058 84 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm "Marked Exart" is at the notified at another any injury or other traumatic event, I'm "Marked Exart" is at the notified at agree. 10d. Inside City Limits 10b. County 10c. City, Town or Location Maryland Frederick Adamstown 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 3200 Baker Circle 21710 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 🛣 No Specify: White Specify: 3 Nidowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Medical Librarian 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Health Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ralph Irwin Sasse Kathryn Ringgold ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Kitty Thompson, Daughter P.O. Box 1742, Frederick, Maryland 21702-1742 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory Jan 31,2009 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilities P.A. Funeral Home 21. Signature of Funeral Service Licens M00706 106 E Church St, Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 30 min ardiopulmonary disease or condition resulting in death) /Medical Due to (or as a const uence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or Attending Physician: The law requires that the death certificate be executed Angiograp

Due to (or as a consequence of): icate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒No Month Ye ar Day 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ SERC 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 Yes 2 No 2)X(No 1 □ Yes funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2⊠ No 1 inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1X Natural 5 Pending 1 ☐Yes 2 ☐ No 2 ☐ Accident investigation within 24 hours after death

To the Funeral Director:
completely filled in by the i 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number M.D January 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) House Avenue, Frederick, Maryland 21701 , M.D Fox 101

Registrar

State

DHMH 17 Rev 1/2001 0

DIT

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jan 29, 2009 **Physician** William Toepfer 3:45am [™] Thomas /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 15504 Baltimore Pike, NE Cumberland Allegany Birthplace (State or Foreign Country)
 OH 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Jul 8, 1930 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Min 1 → M 2 □ F 217-28-7679 78 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If then 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite Medical Examinar must be modified. 10c. City, Town or Location 10d. Inside City Limits 10b. County MD Allegany Cumberland 1 □ Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15504 Baltimore Pike, NE 21502 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 □ N Baltimore, Maryland 21215-0036 Specify Specify: 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Precision Sheet Metal Worker Allegany Tech. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Meyers Toepfer Grant unknown ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
15504 Baltimore Pike Cumberland MD 21502 19a. Informant's Name/Relationship (Type. Print) Connie Toepfer wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Fremation 3 ☐ Removal from State Scarpelli Funeral Home, P.A. 1/30/2009 MD Cresaptown 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligens 22. Name and Address of Facility and Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part F. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failufe. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Caus (Final disease or condition resulting in death) Panercahe **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical for use as the 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown eral Director: After this certificate has been s filled in by the funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an DSteopenia 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case re erred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital an: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check only one) 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RU59699 -MD Jerry E Harry Fish CRNP 1/30/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Terry E (Hervey FNP CRNP 621 Kelly Road Cumberland, MD 21502

31. Date filed (Month, Day, Year)

32. Registrar's Signature State FEB 0 4 20 Registrar

DK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 9:45 P Richard Lee Vogel, Sr. 1/20/2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** Caroline Nursing Home Caroline Denton
If Under 24 Hrs. Birthplece (State or Foreign Country) If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Min 1**∑**M 2□F Hours Yrs. Director 1/10/1925 <u>122-18-8113</u> 84 New York Usuat Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f ehow other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√ No Directo Maryland Caroline Ridgely 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō or itams 23a 11021 Central Ave. 21660 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2☑ Married 1 ☐ Yes 2 No Specify þ 3 Widowed 4 Divorced "natural" White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then eny injury or other traumatic event, the Me College (1-4or 5+) Elementary/Secondary (0-12) Contractor Utility 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Raymond John Vogel Hattie Amelia Bartlett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doreen Elizabeth Vogel / Wife 11021 Central Ave., Ridgely, MD 21660 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
'4 ☐ Donation 5 ☐ Other (Specify) 1/22/2009 Cambridge, MD Mid Shore Cremation Center 21. Signature of Funeral Service Licensee 22. Name and Address of Facility once Mid Shore Cremation Center, 2272 Hudson Rd., Cambridge, MD 21613 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition aspiration Buennan **Physician** /Medical resulting in death) Due to (or as a consequence of) Examiner ontwollawic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit advanced Picks disease that initiated events resulting in death) Last and Due to (or as a consequence of): the attending physician Certification; To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Year detached for Month Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. page 2 should be 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy performed 1 Yes 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2010 2 ER/Outpatient 3 DOA this filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Hospitel or Attending 5 Pending investigation 1 Yes 2 No death. 2 Accident hours after deat 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a. Certifier completely Medi and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MO 00053255 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lednum Are Preston MD Butler 134 Melinda

Registrar

State

31. Date filed (Month,

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

park

09-00637 Monikki Willis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 03180

		- For State	•	Certifi	cate of	Death			Reg. No.	
Physicia	_	egistrar 1. Decedent's Name (First, Middle	e,Last)					2. Date of De Month	Day Year	3. Time of Death 0637 hrs
dical Examir	ner	MONIKKI	WILLIS					January	21, 2009	
		4a. Facility Name (if not institution	n, give street and number)		41	c. City, Town, or L	ocation of D	eath . :	4c. County of I	
		Shady Grove Adventis	st Hospital			Rockville				•
Funeral		5_ Social Security Number	·6. Sex 7. Age	e (in yrs. last b	oirthday)	If Under 1 Year Months Days	If Under 2	Min		oreign
Director		218-94-7709	1 M 2 XF	37	Yrs.	Months Days	Hours	July	30,1971	Country) MD
		Usual Residence of Decedent								10d. Inside City Limits
any	T	10a. State 10b. County		10c. City, To						1 X Yes 2 No
* .	_	MD Mon	ntgomery		Ro	ckville				21
arykar 8a-f s	용	10e. Street and Number		I		10f. Zip Code			10g. Citizen of What	t Country?
nith the Maryland s 23a or 28a-f show a notified at once.	Director	403 McLean	Court			208	50		U.S.	Α
with t		11. Marital Status	12. Was Decedent		13. Was	Decedent of Hisp	anic Origin	? (Specify Yes or	No- 14. Race - White.	American Indian, Black, etc.
eath item	Funeral	1 X Never Married 2 M	Armed Forces?		If Yes, specify Cuban, Mexican, Puerto F			derio racan, cic.,		0.0.
fler d		3 Widowed 4 Div	vorced If Yes, Give Year			Yes 2 X No				Black
ours a	Completed by	15. Decedent's Education (Spe	cify only highest grade cor	mpleted) 16	Sa. Decedent	t's Usual Occupationst of working life.	on (Give kin DO NOT us	d of work done e retired)	16b. Kind of Busi	ness/industry
72 hc	ete	Elementary/Secondary (0-12)	College (1-4 or	5+)					Dav. 0	one Contor
036 ithin r tha	ם	12th			Chil	d Care			le, Maiden Surname)	are Center
5-0 led w Hygic		17. Father's Name (First, Middle								
21215-0036 and be filed within 7 Mental Hygiene. marked other than ic eyent, the Medica	a	Lewis Bur			10h Mailanc	Address (Street	Tere	sa Dari	ene Will Number, City or Town.	State, Zip Code)
D 21215-0036 shouldbe filed within 72 hours after death with the Maryland and Mental Hygene. 7 is marked other than "natural", or items 23a or 28a-f sho ratic eyent, the Medical Examiner must be notified at once.	မ	19a. Informant's Name/Relations		1						
and 2 sho Tealth and Tealth and Tem 27 is		Teresa D. V	VIIIIS (MO	20b. Pla	ce of Dispos	ition (Name of cen	netery,	Date	20c. Location - 0	City or Town, State
ore, selan		1 X Burial 2 Cremation	n 3 Removal from S	tate cre	matory or oth	ner place)	1	7 /20 /00		.: -1- MD
imore, MD 21215-0036 Pages I and 2 shoulded filed within 72 hours after ment of Health and Mental Hygiene fant: If iten 27 is narked other than "natural", or other traumatic event, the Medical Examiner.		4 Monation 5 Other S	ecify:	Rest	thave	n Cem.	of Facility	$\frac{1}{30}$	Freder	HOME, P.A.
Baltimore, permit. Pages I a Department of He Important: If ite injury or other to	1	21. Ignalure of Fun ral Service	Lice	11/1	22. N	lame and Address	of Facility	SNOWDEN	POCKWIL	le,MD 20850
™ % ♥ ₹ 1.5	1 3	Monta XI	Svariae	0 ()91 (24	be made of dving	SILTII	diac or respiratory	arrest, shock, or hea	rt Approximate Interval
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory an each line. Between Onset and Death								
waminer	9	Immediate Cause (Final disease a. Probable cardiac arrythmia								
		or condition resulting in death) Due to (or as a consequence of):								
	<u>_</u>	Sequentially list conditions, if any, leading to immediate	Due to (or as a con:	sequence of):						-, -,
	E cause. Enter Underlying Cause									
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760, icate be physiciate the burie		IF FEMALE: 23b. Was decedent pregnant in	the 23c. If yes, outc	ome of pregna		etal death 3	Ectopic	pregnancy	Month	Day Year
Box 68's death certificate attending ed for use as	sician/	past 12 months?		at time of deat	_ =	ther (Specify)		,	200.0	
SOX leath e atte for u)sic	1 Yes 2 No 9 ✔ U	nknown g Unknown		• •	410. (-7 77				
D. BC t the des by the s	Phy	Part II. Other significant cond	litions contributing to de	ath but not res	ulting in the	underlying cause	given in Par			bute to the cause of death?
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ion of Vital Records, P.O. Box 687 trending Physician: The law requires that the death certific leath. The After this certificate has been signed by the attending, the funeral director, page 2 should be deached for use as t	å	25. Was case referred to medi examiner?		itient 2 🗸 E	=P/Qutnatier		Other,	Nursing Home	5 Residence 6	Other:
F Kit Physic r this	<u>۵</u>	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of I		28b. Time of		iry at Work		cribe how injury occurr	red
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SiOr siftence death ctor:	j ŧ		continution	Finium - At hor	me farm stre	eet factory office	building, etc	28f. Loca	tion (Street and Numb	er or Rural Route Number, City
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14 B B 15	29a Certifier 20 1/2 29a Certi								r as stated.	
n 24 h									due to the cause(s)	
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date of and manner stated. 29b. Signature and title of certifier 29c. License number									ned (Month, Day, Year)	
	2	290. Signature and title of Cert	11 1				.M.E.		January 22, 2009	
		Hamely fre	Thall, MI	7	00-1					
		30. Name and address of pers		or death (Item edical Exar	zsa) niner 1	11 Penn Stre	et. Baltim	ore, MD 2120	01	
		Pamela E. Southall,	I no Basis	strar's Signatu		Chirode	-, -			
	State	31. Date filed (Month, Day Yea	7 2000 32 Regis	sirai s signatu	To ha	12.1				

		-	For State Registrar	State of Ma	-	partment of F Certificate of		nental Hygle Reg.	2009	03181
ľ	Physicia	an	1. Decedent's Name (First, Middle, La	-				2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give	EEMS		4b City Town o	or Location of Death	LIANUARY	16 2009 4c. County of Dea	
). (2	Examin	er	Calvert County Nursing			Prince Free			Calvert	
	Funeral		5. Social Security Number 6. S		(In yrs. last birtho	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	ear) 9. Bir	thplace (State or Foreign ountry)
ij.	Director		220-34-8580 Usual Residence of Decedent		89 ^{Yrs})		March 7, 19	19 Mar	yland
	yland yland at		10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limits
	e Mar Ba-f sl	Director	MD Calvert		Lusby					1 ☐ Yes 2 ☒ No
	with th	Dire	10e. Street and Number			10f. Zip Code			. Citizen of What C	ountry?
	ms 23	Funeral	581 Sollers Wharf Road	12. Was Decedent E	ver in U.S.	13. Was Decedent of H If Yes, specify Cub	20657 Hispanic Origin? (Sp		ISA 14. Race - Am	
Q	after or ite		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give	0	1 ☐ Yes 2 ☑ No		o Rican, etc.)	Black, Whi	te, etc.
2000	72 hours after death with the Maryland 'natural", or items 23a or 28a-f show di.al Examiner must be notified at	ed by	3√ Widowed 4 Divorced 15. Decedent's E	Year or Dates:		ecedent's Usual Occup	pation	16	b. Kind of Business	Black
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7	filed within Hygiene. other than ' ent, the Me	Com	3	College (1-40) 3-	·	mestic				e Else's Home
	be file	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam	ne (First, Middle, Ma	iden Surname)	
Z	2 should be filed w n and Mental Hygie is marked other t raumatic event, th	유	John 19a. Informant's Name/Relationship (Watts Type, Print)	19b. N	failing Address (Street	and Number or Ru		ster Johnson City or Town, State,	
<u> </u>	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mertal Hygiene. If Health and Mertal Hygiene "natural", or items 23a or 28a-f show tem 21 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Betty Gorman - Daught			30 Bayside Ro			-	
e,	0 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐		20b. Place of D	isposition (Name of crematory or other pla			c. Location - City o	
Saltimor	thent of trant: If ite		4 □ Donation 5 □ Other (Special	ý)	St Johr	UM Church C		2009	usby MD	
<u>a</u>	permit. Pag Department Important: I any injury o	, ,	21. Signature of Funeral Service Lice	0 00		22. Name and Addre	,	1 Dans Bassh	Dd Drings Fr	aderial MD 20679
r			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death. Do not					Approximate Interval Between
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Ď,	ificate be executed g physician and as the burial-transit		resulting in death) Last	Due to (or as a	a consequence of)	:				
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XOX ROX	death certifi e attending d for use as	M/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	pf pregnancy 2 □ Fetal death	3 □Ectopic pregnanc	214		23d. Date of de	*
о В	e deat the atte	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown		5 ☐ Other (specify) _			Month	Day Year
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	sician certifi irector	Be c	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	nt 2⊟ER/Outp	ationt 30 DOA Ot		ath (Check only one) lome 5☐ Residen		anifel
0	Attending Physician: or death. ector: After this certific by the funeral director,	n: To	27. Manner of Death	28a. Date of Inju	ry 28b. Tir	ne of 28c. Inju		28d. Describe how		еспу)
SIO	endln sath. or: Aff	catio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b	n		M 1]Yes 2 □ No			
DIVISION	pital or Atten ours after deatl eral Director: filled in by the	Certification:	4 Homicide determined		ury - At home, farn c. (Specify)	n, street, factory, office		28f. Location (Stre City or Town,		Rural Route Number,
	poltal ours eral filled			hysician: To the best						
	To the Hos within 24 ho To the Fun completely	Medical	one)	mîner: On the basis of and manner sta						
_	To the within 2 To the comple	2	29b. Signature and title of certifier	v.c	Sur ar	29c. Licer	5665	3	d. Date signed (Mo	nth, Day, Year) - 2 0 0 S
			20 Name and address of person who	completed cause of d	eath (Item 23a) /T	vne Print)	C110 C	Carochae		
X	W 5		5851-	Deale. 32. Registr. 1 2009	chi	nenton	Road	Deale	e mto	2075)
		ate	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	6 1	80			
	Regist	rar	JANZ	TAUDA	eneway	a. Sparker	B			

			For State Registrar	State of Mar		rtificate of			ene g. No.2 9	03182
ı	Physici	an	1. Decedent's Name (First, Middle, Last Delores Jeanet) te Washingt	on			2. Date of Death Month January	P8, 2009	3. Time of Death 4:16P M
and i	/Medio		4a. Facility Name (If not institution, give	street and number)			r Location of Death		4c. County of Death	
	Funeval		57 Riverside Rus 5. Social Security Number 6. Se		In yrs. last birthday)	India	n Head If Under 24 Hrs.	8. Date of Birth	Charl	es place (State or Foreign
ı	Funeral Director		217-42-3386	□ M 2□XF	65 Yrs.	Months Days	Hours Min. F	8. Date of Birth (Month, Day, ebruary	15,1943 M	aryland
	yland		Usual Residence of Decedent 10a. State 10b. County	11	0c. City, Town or Lo	cation				10d. Inside City Limits
	he Mar 28a-f sl	ector	MD Charle	es	India	n Head				1 Yes 2 □ No
	h with t	al Dir	10e. Street and Number 57 Riverside Run	Drive		10f. Zip Code 2064	0	10	g. Citizen of What Cou USA	ntry?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, The Medical Examination insists another office.	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 H Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Nas Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin? (Spe an, Mexican, Puerto F Specify:	city Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify:	
21215-0036	in 72 ho n "natu Nedical	oletec	15. Decedent's Edu (Specify only highest grad	le completed)	16a. Deced	dent's Usual Occup kind of work done	eation during most of working	ng 1	6b. Kind of Business/Ir	ndustry
	ed withi ygiene. ier thar t, he	Comp	Elementary/Secondary (0-12)	College (1-4or 5+)			rsing Assi	istant	Nursing	
Maryland	ld be file lental H ked oth Ic even	To Be	17. Father's Name (First, Middle, Last) William Henry	Whalen			18. Mother's Name Alice ((First, Middle, M. G. Farme	,	
Aary	2 shou n and M is mar raumat	۲	19a. Informant's Name/Relationship (Ty	*	ŀ				City or Town, State, Zi	p Code)
	t and f Health item 27 other t		Allandra Washing		20b. Place of Dispo		White Pla		20695 Oc. Location - City or To	own, State
Baltimore,	Pages tment o tant: If i jury or		1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	Tellioval Ilolli State	St. Ignat	ius Ceme	tery 1/24/	/2009	Port Tobaco	co,Marÿland
Ball	permit Depart Import any In		21. Signature of Funeral Service Licens	E hold	0945		ECHOLS FUN Mary's Ave		•	546
			23a. Part 1. Enter the disease, or compleshock, or heart failure. List only of Immediate Cause (Final	ications that caused the				r respiratory arre	st,	Approximate Interval Between Onset and Death
in the second	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a co		c c	neer			
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68760,	rtificate be executed ng physician and as the burial-transit		resulting in death) Last	Due to (or as a co	onsequence of):					
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.O. Box	Physician: The law requires that the death cer this certificate has been signed by the attendin ral director, page 2 should be detached for use	Physician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tin 9 ☐ Unknown	Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of delive Month	pery Day Year
<u>റ</u> റ	w requires that s been signed b should be deta	by Pt	Part II. Other significant conditions con		_	nderlying cause give	en in Part I.		acco use contribute to t	
Records,	w requi	leted	1 January Charles	. tendo	mia			1 ∐ Yes 24a. Was an	2 No 3 Pro	
	siclan: The law certificate has be rector, page 2 s	Completed	25. Was case referred to medical					autopsy perform 1 □ Yes 2	ed? death? ZNo 1 ☐ Yes	opsy findings available ompletion of cause of
<u></u>	hysiclan: his certific I director,	To Be	examiner?	Hospital: 1 ☐ Inpatient	2 ER/Outpatien	t 3 DOA Othe	26. Place of Death er: 4 ☐ Nursing Hom		ice 6 □Other <i>(Speci</i>	fy)
ouo	ng fe	tion:	27. Manner of Death 1 Natural 5 □ Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Ye	28b. Time of Injury	28c. Injur Worl	y at 2	8d. Describe how		
Division of Vital	ial or Attending s after death. al Director: After ed in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (- At home, farm, stre Specify)			8f. Location (Stre City or Town,	eet and Number or Run State)	al Route Number,
	Hospit 14 hour Funera tely fill	Medical C	29a. Certifier (Check only one) 17 Certifying Physical Exami	sician: To the best of mer: On the basis of ex	ny knowledge, death amination and/or inv	occurred at the tirvestigation, in my o	me, date and place, a pinion, death occurre	and due to the car ed at the time, dat	use(s) and manner as te and place, and due t	stated. o the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	and manner stated		29c. License		- 5	d. Date signed (Month,	Day, Year)
			Janes	whel	Simo		90837	V Ja	anuary 20,	2009
in	D10		30. Name and address of person who co Paul Pritchett, M	ompleted cause of death 1.D. Mon-R	h (Item 23a) (Type, F os Bldg.	^{Print)} La Plata	,MD 20646	•		
		State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature 33. Date filed (Month, Day, Year) 34. Date filed (Month, Day, Year) 35. Registrar's Signature 36. Aparella								

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			For State	C	ertificate of	f Death		Reg.				
edi	Physicia	n/ ¹	. Decedent's Name (First, Midd MATTHEW DAN					2. Date of Death Month D January 12,		3. Time of Death 2125 hrs		
		4	a. Facility Name (if not institution			4b. City, Town, or L Easton	ocation of Death		4c. County of D Talbot	eath		
			Easton Memorial Hos		s. last birthday)	If Under 1 Year	If Under 24Hrs.	8. Date of Birth(MM/DD/YYYY) 9	, Birthplace (State or		
	Funeral Director	'	5. Social Security Number		Yrs	Months Days		JULY 7,	F	oreign Country) MD		
	Director		218-92-0298 Usual Residence of Decedent	1XM 2 F 45	118	·		10 OH 7 7 9				
	any		10a. State 10b. County	10c. C	City, Town or Loca	tion				10d. Inside City Limits		
	≥ .	_	MD TA	ALBOT	EAST	CON			1 Yes 2 X No			
	Maryland 28a-f show d at once.	Director	10e. Street and Number			10f. Zip Code		10g	10g. Citizen of What Country?			
	ith the N 23a or notified		26560 PRESQUI	ILLE FARM DRIVE		2160		if Var as Na	USA 114 Page /	American Indian, Black,		
	items 2	uneral	11. Marital Status 1 Never Married 2 X	12. Was Decedent Ever i Armed Forces?	1f '	as Decedent of His Yes, specify Cuban	panic Origin? (Sp , Mexican, Puerto	Rican, etc.)	White, 6			
	or deat	ᆲ		1 Yes 2 X N	lo 1	Yes 2x No	specify:	1	Specify: V	WHITE		
	5-0036 led within 72 hours after death with the Maryland Hygique other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once	<u>a</u>		or Dates: pecify only highest grade completed		ent's Usual Occupat	ion (Give kind of v		6b. Kind of Busin	ness/Industry		
	72 hou	Completed	Elementary/Secondary (0-12		during r	most of working life.	. DO NOT use rea	red)	DDTILLO	E ESTATE		
į	od of thin of the other	립	9	0	CAI	RETAKER	40 Matter de Nome	e (First, Middle, Ma		E ESTATE		
j	15-003 filed within Hygiene. d other th , the Medi	ပ္ပို	17. Father's Name (First, Middle					E M. PEAR				
	21215-0036 Juld be filed within 7 Mental Hygiene: marked other than c event, the Medica	മി	HOLTON E. WO		19b. Mailii	ng Address (Stree	et and Number or	Rural Route Numb	er, City or Town,	State, Zip Code)		
	Sho and and 7 is	-	TINA M. WOOT		265	60 PRESQU	JILLE FAI	RM DRIVE,	EASTON	, MD 21601		
	一 智田田田		20a. Method of Disposition		Ob. Place of Dispo	osition (Name of ce other place)	metery,	Date	20c. Location - C	city or Town, State		
	MOFE Pages 1 nett of Fi nut: If i		1 X Burial 2 Cremati 4 Donation 5 Other		WOODLAWN	MEMORIAI		1/20/200		N, MARYLAND		
	Baltimore, permit. Pages I an Department of Her Important: If ite		21. Signature of Funeral Service	ce Licensee	22. F	Name and Address	s of Facility ELFENBE	IN & NEWN	AM FUNE	RAL HOME PA		
			Joseph M. E	or complications that caused the d	eath Do not enter	00 S. HAI	RRISON S'.	or respiratory arre	ot, shock, or hear	t Approximate interval		
	Physician Vedical		failure. List only one caus	se on each line.	odin Bo not sino					Between Onset and Death		
	aminer		Immediate Cause (Final disea or condition resulting in death)		nce of):			at i				
			Sequentially list conditions,	b								
		ine	if any, leading to immediate cause. Enter Underlying Cause		nce of):							
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	760, icate be executed physician and the burial - transit		Гілиосивсь	damended								
	ial ia	/Medical	UNPENDED	23c. If yes, outcome of	pregnancy			in:	23d. Date of o	delivery		
	8760, tificate be ng physic as the bur	Ž	IF FEMALE: 23b. Was decedent pregnant in past 12 months?		2	Fetal death 3	Ectopic pregr	nancy	Day Year			
	Box 687 death certiff the attending	sician		4 Pregnant at time Unknown g Unknown	of death 5	Other (Specify)						
	D. Be t the der by the a	Phy		nditions contributing to death but	not resulting in th	e underlying cause	given in Part I.	23e. Did to	bacco use contrib	oute to the cause of death?		
	ires that the signed by	5	1	sae; chronic alcohol abuse				1 Yes	2 No 3	Probably 4 🗸 Unknown		
	v require	Completed						24a. Was autop		Vere autopsy findings available rior to completion of cause of		
	e law e has l ge 2 sh	ם						perfor		eath? Yes 2 No		
	tal Rec		25. Was case referred to med	dical		26.Pla	ce of Death (Chec	k only one)				
	of Vital Records, ng Phystchan: The law requir Nher this certificate has been s meral director, page 2 should 1	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpati				Residence 6	Other:		
	ion of tending Pheath.	<u> </u>	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time		jury at Work? Yes 2 No	28d. Describe	now injury occurre	eo ,		
	ttendi death.	atio		Pending nvestigation 28e. Place of Injury				28f Location (Street and Number	er or Rural Route Number, City		
	Division of Vital Records, P.O. Box 68 the Hospital or Attending Phystelm: The law requires that the death certifin 24 hours after death. the Pumeral Directory. After this certificate has been signed by the attending majerley filled in by the funeral director, page 2 should be detached for use as	Certification:	d	Could not be 28e. Place of Injury (Specify)	- At nome, rarm, s	street, ractory, onice	bullding, etc.	or Town, S		•		
	Divis ospital or A hours after uneral Dire		4 Homicide	- Physician, To the heat of my kn	owledge, death or	ccurred at the time,	date and place, a	nd due to the caus	se(s) and manner	as stated.		
	To the How Within 24 h To the Function	Medical	(Check only one) 2 Medical!	Examiner: On the basis of examina	ation and/or invest	tigation, in my opini	on, death occurre	d at the time, date	and place, and d	lue to the cause(s)		
	To the within To the Comple	Mec	29b. Signature and title of ce	and manner stated.		29c. Lice	nse number			ed (Month, Day, Year)		
			O.C.M.E.							January 13, 2009		
_	TLS 3			rson who completed cause of deat			01	MD 0400	1			
	3			ollak MD. Assistant Med			Street, Baltim	ore, MD 2120	1			
		State stra		ear) 32. Registrar's 3	Signature .	have						

OCME

ORIGINAL

E-Amend#29D per Phy. State of Maryland / Department of Health and Mental Hygiene State Registrar 1/12/09 AAOO HEALTH DEPT. OMH Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Webb 1009 /Medical . Facility Name (If not institution, give street and number) City, Town, or Location of Death County of De Examiner Baltimore Washington Anne Surnie Social Security Number ear If Under 24 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth (Month, Day, Hours Days Min. Country) 1 □ M 2 F 461-25-5192 86 Director 29, Texas 1922 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f shov Examiner must be notified at MD Anne Arundel Severna Park Director 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 21146 USA 307 Westhaven Drive or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after t Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or iter any Injury or other traumetic event, the Modical Exemina-1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 No Specify. White Specify: 3 ₩ Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Grayson Campbell Sarah Holbrook Gibbs ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 308 Westhaven Drive Severna Park, MD 21146 Susan Wincek/ daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 08, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Jan. Metro Crematory, INC. Baltimore, MD 5 ☐ Other (Specify) 4 Donation 2009 Signature of Funeral Septice Licens Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 Part 1. Enter the disease, or shock or heart failure. List omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease of condition **Physician** days in death) /Medical (or as a consequence of) Examiner neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) the attending physician P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 X No 9 Unknown 9 Unknown ntributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 1 /6/2009 29b. Signature and 29c. License number f person who completed cause of death orkhov Registrar's Signat 31. Date filed (Month, Day, State Year!

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Registrar

12

State of Maryland / Department of Health and Mental Hygiene 2009 03185 Certificate of Death

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		Decedent's Name (First, Middle, Last)		2	Date of Death	Day Vass	3. Time of Death
Physicia /Medic		Eugene Bayard Walp, Sr.			Month January	16, 2009	7:05P M
Examin		4a. Facility Name (If not institution, give street and number) 4	b. City, Town, or Location	n of Death		4c. County of Death)
		Heritage Harbour Health Center	Annapolis			Anne Arur	nde1
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)			B. Date of Birth (Month, Day,		nplace (State or Foreign intry)
Director		151-18-8372	violitis Days Flours	S IVIIII.	9/4/1926	New	Jersey
pu ,		Usual Residence of Decedent					1011 11 01 11 11
aryla shov	_	10a. State 10b. County 10c. City, Town or Locat	ion				10d. Inside City Limits
Ba-f	cto	Maryland Anne Arundel Annapolis					1 □Yes 2 🕅 No
vith the Maryland	Director	10e. Street and Number	10f. Zip Code		10	g. Citizen of What Co	intry?
should be filed within 72 hours after death with the Maryland and Mental Hygiene. In marked other than "natural", or items 23a or 28a-f show umatic event, I'm Medical Examinations in this countillation.		2504 Painter Court	21401			USA	
r de	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Wa Armed Forces? 13. Wa	s Decedent of Hispanic C es, specify Cuban, Mexic	Origin? (Speci can, Puerto Ri	ify Yes or No- can, etc.)	14. Race - Amer Black, White	
or i	by F	1 □ Never Married 2 □ Married 1 □ Married	Yes 2∭ No Specif	fy:		Specify: Wh	ite
hour:	D b	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	Ma Harral Occuration		11.4		
"nat	ete	(Specify only highest grade completed) (Give kir	nt's Usual Occupation of work done during mo on NOT use retired)	ost of working	· 4	6b. Kind of Business/I	noustry
withi ene. than	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	ngineer		1	Federal Go	vornmont
filed Hygi ther		17. Father's Name (First, Middle, Last)		ther's Name (First, Middle, Ma		vernment
d be ental ced c	o Be	Andrew Samuel Walp	Tr	ma Mir	iam Clar	ringbold	
houl nd M marl mati	F		Address (Street and Num				in Cade)
d 2 s Ith ar 27 is trau			eptune Place				p code)
1 an Hea tem 2		20a. Method of Disposition 20b. Place of Dispositi	on (Name of	Dat		0c. Location - City or	own, State
ages int of t: If it		1 VV Burial 2 Li Gremation 3 Li Removal from State 1	tory or other place)	1 /00 /		•	
it. Partme		4□Donation 5□Other (Specify) Maryland \(\) 21. Signature of Funeral Service Licensee \(\) 22. \(\)	eterans Cen	1/22/	2009 C	<u>rownsyille</u>	, Maryland
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; any injury or other traumatic event, the Wedlen Evagnee.		20.7	lame and Address of Fac 3 Solomons	Taland	ge P. Ka	alas Funer	al Home
		23a. Paul. Enter the diseast, or comply allons that caused the death. Do not enter					. ZIU3/ Approximate
	5	shock, or heart failure. List only of e cause on each line.	are mode or dying, such a	as cardiac or	respiratory arres	,	Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)					U12K3CK2A
Examiner		Due to (or as a consequence of):					
	-e	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):					
uted I nsit	i i	cause. Enter Underlying Cause (Disease or Injury					
execting and all-tra	Examiner	that initiated events resulting in death) Last c					
e be	cal	C _d					
g phy as the	cian/Medical	V					
ndin use	N/	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy				23d. Date of del	verv
death e atte d for		in the past 12 months? 1 Dive birth 2 Fetal death 3 E	ctopic pregnancy Other (specify)			Month	Day Year
t the by th	Physi	9 Unknown			1	-	
s tha	by P	Part II. Other significant conditions contributing to death but not resulting in the under	erlying cause given in Par	rt I.	23e. Did toba	acco use contribute to	the cause of death?
quire en siç uld b		NONE			Yes	s 2 □ No 3 □ Pr	obably 4 Unknown
aw re	Completed				24a. Was an		topsy findings available
The I	E				autopsy	ed? death?	ompletion of cause of
an: rtifica tor, p	Φ	25. Was case referred to medical	26. Pla	ace of Death (1 ☐ Yes 🔑	-	2 □No
ysici is ce direc	To B	examiner? 1 Yes No Hospital: 1 Inpatient 2 ER/Outpatient	_ Other: V			nce 6 Other (Spec	cify)
ig Ph ter th neral	ü	27. Manner of Death 28a. Date of Injury 28b. Time of (Month, Day, Year) Injury	28c. Injury at Work?	-		v injury occurred	,
ath.	atic	2 Accident investigation	M 1 ☐Yes 2[□No			
r Atte er de recto	tific	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	t, factory, office	28	If. Location (Stre	eet and Number or Ru State)	ral Route Number,
talo rsaft alDi	Certification:						
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death of Check only one) Certifying Physician: To the basis of examination and/or inversand manner stated.	occurred at the time, date stigation, in my opinion, d	and place, ar death occurre	nd due to the ca d at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
o the	Med	29b. Signature and title of certifier	29c. License numbe	er	29	d. Date signed (Monti	n, Day, Year)
FSFO		1	D3903	37			_
		30. Name and address of person who completed cause of death (Item 23a) (Type, Pr		,		9 JAN	C
ICH	1	DOUGUSS MITCHELL 2001 ME	DICAL PAR	KWY			
Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature					

			1 - For State Registrar	State of Mary		artment of rtificate o			giene Reg. N. 00	9 03186
	Physici /Medic Examin	cal	Decedent's Name (First, Middle, La NONA K 4a. Facility Name (If not institution, give	WINDHM	M		n, or Location of De	2. Date of De Month path	Day 4c. County of	
	Funeral Director		259-48-8477		yrs. last birthday) Yrs.	Annapo If Under 1 Ye Months Day	ar If Under 24 H		rth ay, Year)	Arundel 9. Birthplace (State or Foreign Country) Alabama
;	Ba-f show	ector	Usual Residence of Decedent 10a. State 10b. County Maryland Carroll		: City, Town or Lo	g	.,			10d. Inside City Limits 1 ☐ Yes 2 ※ No
200	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If them 27 is marked other then "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Madical Examinal must be notified at once.	by Funerai Directo	10e. Street and Number 5880 Springmount 11. Marital Status 1□Never Married 2□ Married 3□Widowed 4 ☑Divorced	Court 12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		10f. Zip Cod 2178 Was Decedent of Yes, specify C	64 of Hispanic Origin? cuban, Mexican, Pu	(Specify Yes or No erto Rican, etc.)		/hat Country? USA - American Indian, k, White, etc. - White
00-01212	led within 72 hou ygjene. her than "natural it, the Medical E	Completed b	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	(Give	dent's Usual Oc kind of work do DO NOT use rel	ne during most of v tired)		16b. Kind of Bus	siness/Industry
Iylallu	2 should be til and Mental H Is marked ott sumatic even	To Be	17. Father's Name (First, Middle, Last, Henry Clayton I 19a. Informant's Name/Relationship (Kirkland, Sr.		na Address /Stre	Myra	Vertis Rural Route Numb	Santt	
≅ : ນົ	s 1 and 2 s 1 Health an tem 27 Is other traus		Stacey Poole/Daugl	nter		Herons N	Vest Cour	t Annapol	is,MD. 2	
	permit. Pages Department of I Important: If its any injury or o once.		1 Burial 2 Cremation 3 C 4 Donation 5 Other (Specification of Funeral Service Licental Serv	Entombment	\rlington	n Mem. I 2. Name and Ad	Park 1/2 dress of Facility G	eorge P.	KalasFur	Georgia neral Home c,MD.21037
	Physician /Medical Examiner		23a. Part1. Enter the disease, or conshock, or hear failure. List only immediate Cause (Final disease or condition resulting in death)	blications that caused the one cause on each line. a Due to (or as a cor		ter the mode of o	dying, such as card	liac or respiratory a	rrest,	Approximate Interval Between Onset and Death
,00,	ate be executed by sician and the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c						
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r (chilo	w requires tha been signed I should be det	by	Part II. Dther significant conditions of	contributing to death but no	t resulting in the u	nderlying cause	given in Part I.	23e. Did 1	_/	ibute to the cause of death? 3 Probably 4 Unknown
ישרו ומי	ilctan: The taw recentificate has be rector, page 2 sh	e Completed	25. Was case referred to medical					1 ☐ Yes	psy promed? de 22 No 1	Vere autopsy findings available rior to completion of cause of eath?
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	ending Planth. Seth. Set	ertification;	27. Manner of Death 1 Natural 5 ☐ Pending ☐ Accident investigatio		28b. Time o Injury		njuryat Work? □Yes 2□No	28d. Describe	how injury occurre	ıd
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	te Hosp 24 hou se Fune setely fil	edicai	29a. Certifier 1 Certifying Pt (Check only 2 Medical Examone)	nysician: To the best of my niner: On the basis of examiner and mapper stated.	knowledge, deat mination and/or in	h occurred at the vestigation, in m	e time, date and pla ny opinion, death oc	ice, and due to the courred at the time,	cause(s) and man date and place, a	ner as stated. nd due to the cause(s)
1	vithir To th comp	Me	29b. Signature and title of certifier	Hein	tam		ense number	3		(Month, Day, Year)
4	4		30 Name and address of person who	completed cause of death	(Item 23a) (Type,	Print) DEY	FENSE H	7GHWAY	ANNA	ory 18 2009 Pous MD 21401
;-	Sta Registr		31. Date filed (Month, Day, Year)	2009 32. Registrar's S	ignature .	barker				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Feb. 2009 Year Ruth E. Adams 3 8100A 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 441 Essexwood Court Baltimore Essex 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 □ M 217 F Min. 214-12-1830 92 24,1916 July MD Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 ☐ Yes 2 → No MD Baltimore Essex 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 441 Essexwood Court 21221 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ※No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: White 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Teletype Operator Armco Steel 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard Seibert Leila Moore 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Adena O'Keeffe /daughter 441 Essexwood Court Baltimore MD 21221 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Bayview Crematory 1 ☐ Burial 2 X Cremation 3 Removal from State Baltimore MD 4109 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Puneral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto. MD Colard Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or comp-shock, or heart failure. List only or lions that caused the of ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer Immediate Cause (Final disease or condition resulting in death) Due to (or as a convequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 1 □ Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐Yes 2 ☐ No 2 10 1 ☐ Yes 25. Was case referred medical examiner? 26 Place of Death (Check only or

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

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permit. Pages 1 and 2 should be filed within 72 hours after of Dipartment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or itel any injury or other traumatic event, the Medical Examination

Baltimore, Maryland 21215-0036

death with the Maryland

page 2 director. funeral

The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

or Attending Physician:

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physician and the burial-transi attending p the signed by the peen hash After this certificate Medical Certification: To s after death. filled in by the within 24 hours a

Hos	spital: 1 Inpatient 2	BR/Outpatient	3 □ DOA	Other:	4 🗆 Nursing H	ome 5 Residence	6 ☐ Other (Specify)
	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	280	c. Injury a Work?	t	28d. Describe how inj	jury occurred

 Man → of Death Natural Accident 	5 Pending investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes	2	28d. Describe how injury occurred
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of Injury - At he	ome, farm, street, facto	ory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)

a. Certifier	1 Certifying Physic	cian: To the best of my knowledge	e, death occurred at the time, da	te and place, and due t	o the cause(s) and manner
(Check only	2 Medical Examine	er: On the basis of examination an	d/or investigation, in my opinion	, death occurred at the	time, date and place, and d

(Check only one)		ation, in my opinion, death occurred at the tim	
29b. Signature and	title of certifier	29c. License number	29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MDoncolog

6033624

as stated

State Registrar

completely

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31. Date filed (Month, Day, Year) 5 2009 FFR 0

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Timothy Bourne 2009 January 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug 14, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours Min. 1 X M 2 □ F 50 Maryland 216-56-3589 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 √ Yes 2 □ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5019 Harford Road 21206 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 X Never Married 2 ☐ Married 1 ☐Yes 2 X No Specify white Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 0 set up person trade shows 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ernest L. Bourne Elizabeth Rollins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Larry Bourne/brother 34 King Charles Court Rosedale, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 ○ Other (Specify) in state 21. Sign ture of Euneral Service Licersee Wade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

MD

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

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permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, It a. M. any injury or other traumatic event, It a. M. any once.

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Funeral

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filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Physician/Medical Examiner attending physician and for use as the burial-trar signed by the a d be detached for 2 Completed certificate has briector, page 2 sl Certification: To Be After th funeral

To the Hospital or Attending Physician: The law requires that the death certificate be executed

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within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu

Division of Vital Records, P.O. Box 68760,

	23a. Partil. Enter the disease, or complic shoot, or heart failure. List only on Immediate Cause (Final	cations that caused the death e cause on each line.	h. Do not enter the m	ode of dying,	such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
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nysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c	I death 3 Ectopic				23d. Date of d Month	elivery Day Year
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Complet						24a. Was an autopsy performed?	prior to death?	autopsy findings available completion of cause of
Be	25. Was case referred to medical examiner?			1		h (Check only one)		r rogal
	1 ☐ Yes 2 X No	ospital: 1 🗖 Inpatient 2 🗆	ER/Outpatient 3 ☐ I	OOA Other:	4 Nursing Ho	me 5 Residence	6 ☐ Other (Sp	ecify)
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ertifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, factory)	ory, office		28f. Location (Street City or Town, St		Rural Route Number,
Medical Certification: To	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examir	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death occurrention and/or investigation	ed at the time on, in my opin	date and place, ion, death occur	and due to the cause red at the time, date a	e(s) and manner and place, and du	as stated. ue to the cause(s)
₹	29b. Signature and title of certifier	_	2	9c. License n	umber	29d. I	Date signed (Mor	nth, Day, Year)
	Martine	Blinard	M.D.	ATA	438	946 Jan	uary	28, 2009
	30. Name and address of person who co	mpleted cause of death (Iten	n 23a) (Type, Print)	ion 1	nemore	ial Hosp	sitel,	mD

State Registrar 31. Date filed (Month, Day, Year)

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	/Medio		4a. Facility Name (If not institution, give				r Location of Deati	n s	4c. Co	unty of Death	, ,
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	ems 2	Funeral Director	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of H		pecify Yes or No o Rican, etc.)		Race - Ameri Black, White,	
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DIVISION	or At after d Direct I in by	ertification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	nome, farm, sti ify)	reet, factory, office		28f. Location (City or To	Street and N wn, State)	umber or Rui	ral Route Number,
_	To the Hospital or Attending Powithin 24 hours after death. To the Funeral Director: After to completely filled in by the funeral	S		rsician: To the best of my kn iner: On the basis of examin							
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	0 1 ₹ 1	Σ	29b. Signature and title of certifier	MO		29c. Licens	2539	7/	Zad. Date s	igned (Month,	- 2009
•			30. Name and address of person who on the control of the control o	ompleted cause of death (Ite	m 23a) (Type,	Print)	Pi	0 11	1/1	- /	MAZINO
	8211		MIKHAN	3601- L	och	Kaven	15/00	10	altin	core	111/2/28
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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			epartment of Health and Mental H	•
		1 _ State	epartment of nealth and Mental n Pertificate of Death	0000 00100
		1. Decedent's Name (First, Middle, Last)	2. Date of I	
Physicia /Medic		Randolph	Brice Februit	Day Year 22:46 M
Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
		The Johns Hopkins Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthd)	Baltimore City ay) If Under 1 Year If Under 24 Hrs. 8. Date of 8	n/a Birth 9. Birthplace (State or Foreign
Funeral Director		212 62 5577 . X M 2 F 53	Months Days Hours Min. (Month, Jan.	Day, Year) 22,1956 MD
and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town o	r Location	10d. Inside City Limits
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ath wi		719 N. Lakewood Ave.	21205	USA
ter de items ner m	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2X Married 1 □ Yes 2 ▼No	 Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 	14. Race - American Indian, Black, White, etc.
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 🛣 No Specify:	Specify: Black
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rmit. I partm portar y Injur		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Calvin B. Scruggs Fu	
B B E E S		23a. Part 1. Enter the disease, or complications that caused the part Do not	1412 F. Preston St.	Balto, Md. 21213
- Charles		shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac or respirator	y arrest, Approximate Interval Between Onset and Death
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spital		29a. Certifier 1 Certifying Physician: To the best of my knowledge, c	leath occurred at the time, date and place, and due to t	he cause(s) and manner as stated.
he Ho iin 24 l he Fu	Medical	one) and manner stated.		
5 tive 100	2	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a) (T	Rts - oa	tebruary 02 2009
1.4 A		Amy Parker Ruh		/olfe St, Baltimore, MD, 21287
Sta		31. Date filed (Morth, Day, Year) FEB 0 5 2009 32. Figistrar's Signature	1	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 0231AM Physician 2009 Drooks February Carroll /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE n/a If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex Social Security Number **Funeral** Days Hours Min Months 1 ☐ M 2 ☐ F 71 219 26 1213 Director 2,1937 Feb. Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Pages 1 and 2 should be med many ment of Health and Mental Hygiene.
ment of Health and Mental Hygiene.
tant: If Item 27 is marked other than "natural", or items 23a or 28a-f show jury or other traumatic event, the Medical Examiner must be rediffied at Yes 2□No Director n/a Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21206 USA 4903 Truesdale Ave Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: black ò 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bond Distributing warehouse worker 11+h 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillie Mae Conway unknown ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4903 Truesdale Ave. Balto, Md. 21206 (wife) Daisy Brooks 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Sperial 2 Cremation 3 Removal from State 20a. Method of Disposition permit. Page:
Department o
Important: If I
any injury or
once. Garrison Forest Veterán Cem. OwingsMills, Md. onation 5 Other (Specify) 22. Name and Address of Facility Calvin B. Scruggs Funeral Home ture of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the dath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or learn failure. List only one cause on each line. 1412 E. Preston St. Balto, Md. 21213 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1 HOUR Physician ARDIAC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): physician Physician/Medical the attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) P.0. 9 Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>م</u> PULMONARY OBSTRUCTIVE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy certificate I 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Physician: 26. Place of Death (Check only one) director 25. Was case referred to medical Be examiner? Hospital: 2 ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No · this 1 Inpatient Certification: To funeral 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death or Attending After 1 Natural
2 Accident 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

Registrar

State

29b. Signature and title of certif

31. Date filed (Month, Day, Year)

CYRUS SHAHMAR M.D.

FEB 0 5 2009

4940 EASTERN AVENUE

29c. License number

RES-000

BALTIMORE, MD

29d. Date signed (Month, Day, Year)

February 1, 2009

and manner stated.

Projetrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1. Decedent's Name (First, Middle, Last) DROWN A. Facility Name (II not institution, give street and number) A. Facility Name (III not institution, give street and number) A. Facility Name (III not institution, give street and number) A. Facility Name (III not institution, give street and number) A. Facility Name (III not institution, give street and number) A. Facility Name (III not institution, give street and number) A. Facility Name (III not institution, give street and number) A. Facility Name (III not institution, give street and number) A. Facility Name (III not institution, give street and number) A. Facility Name (III not institution, give street and number) A. Facility Name (III not institution, give street and number) A. Facility Name (III not institution, give street and number) A. Facility Name (III not institution, give street and number) A. Facility Name (III not institution, give street and number) A. Facility Name (III not institution, give street and number) A. Facility Name (III not institution, give street and number) A. Facility Name (III not institution, give street and number) A. Facility Name (III not institution, give street and number) A. Facility Name (III not institution, give street and number) A. Facility Name (III not institution, give street and number) A. Facility Name (III not institution, give street and number) A. Facility Name (III not institution, give street and number) A. Facility Name (III not institution, give street and number) A. Facility Name (III not institution, give street and number) A. Facility Name (III not institution, give street and number) A. Facility Name (III not institution, give street and number) A. Facility Name (III not institution, give street and number) A. Facility Name (III not institution, give street and number) A. Facility Name (III not institution, give street and number) A. Facility Name (III not institution, give street and number) A. Facility Name (III not institution, give	4. Race - American Indian, Black, White, etc. Specify: BLACK d of Business/Industry CO. CITY SCHOOL Surname) Town, State, Zip Code) RYLAND 21239 ation - City or Town, State
4a. Facility Name (If not institution, give street and number) BON SECOURS HOSPITAL 5. Social Security Number 6. Sex 1 Months Days Hours Min. Months Days Min. Min. Min. Months Days Min. Min. Min. Min. Months Days Min. Mi	Country of Death N/A 9. Birthplace (State or Foreign Country) SOUTH CAROLINA 10d. Inside City Limits XX'es 2 No en of What Country? 6.A 4. Race - American Indian, Black, White, etc. Specify: BLACK d of Business/Industry CO. CITY SCHOOL Surname) Town, State, Zip Code) RYLAND 21239 attion - City or Town, State
BON SECOURS HOSPITAL Social Security Number 6. Sex 1	9. Birthplace (State or Foreign Country) SOUTH CAROLINA 10d. Inside City Limits 10d. Inside Ci
Funeral Director Part Par	9. Birthplace (State or Foreign Country) SOUTH CAROLINA 10d. Inside City Limits XXYes 2 No en of What Country? 6.A 4. Race - American Indian, Black, White, etc. Specify: BLACK d of Business/Industry CO. CITY SCHOOL Surname) Town, State, Zip Code) RYLAND 21239 attion - City or Town, State
Director Description of the part of the	SOUTH CAROLINA 10d. Inside City Limits ***X*'es 2 \subseteq No en of What Country? 3A 4. Race - American Indian, Black, White, etc. Specify: BLACK d of Business/Industry CO. CITY SCHOOL Surname) Town, State, Zip Code) RYLAND 21239 ation - City or Town, State
The part of the pa	en of What Country? AA 4. Race - American Indian, Black, White, etc. Specify: BLACK d of Business/Industry CO. CITY SCHOOL Surname) Town, State, Zip Code) RYLAND 21239 ation - City or Town, State
HENRIETTA GREEN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Street Ro	en of What Country? SA 4. Race - American Indian, Black, White, etc. Specify: BLACK d of Business/Industry CO. CITY SCHOOL Surname) Town, State, Zip Code) RYLAND 21239 ation - City or Town, State
HENRIETTA GREEN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Street Ro	A. Race - American Indian, Black, White, etc. Specify: BLACK d of Business/Industry CO • CITY SCHOOL Surname) Town, State, Zip Code) RYLAND 21239 ation - City or Town, State
HENRIETTA GREEN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Street Ro	4. Race - American Indian, Black, White, etc. Specify: BLACK d of Business/Industry CO. CITY SCHOOL Surname) Town, State, Zip Code) RYLAND 21239 ation - City or Town, State
HENRIETTA GREEN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Street Ro	Black, White, etc. Specify: BLACK d of Business/Industry CO. CITY SCHOOL Surname) Town, State, Zip Code) RYLAND 21239 ation - City or Town, State
HENRIETTA GREEN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Street Ro	CO. CITY SCHOOL Surname) Town, State, Zip Code) RYLAND 21239 ation - City or Town, State
HENRIETTA GREEN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Street Ro	Town, State, Zip Code) RYLAND 21239 ration - City or Town, State
HENRIETTA GREEN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Street Ro	Town, State, Zip Code) RYLAND 21239 attion - City or Town, State
HENRIETTA GREEN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Street Ro	Town, State, Zip Code) RYLAND 21239 ation - City or Town, State
HENRIETTA GREEN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or MELVIN GAINER (SON) 5708 MAPLEHILL RD. BALTIMORE, MAI 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) KING MEMORIAL PARK 2-7-2009 BALT	RYLAND 21239 ation - City or Town, State
19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Street and Number or Rural Route Number or R	RYLAND 21239 ation - City or Town, State
MELVIN GAINER (SON) SOUTH BEHTLE RD. BALTIFIORE, FAIR SOUTH BETTER RD. BALTIFIORE, FAIR 20a. Method of Disposition 1 Aburial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) KING MEMORIAL PARK 2-7-2009 BALTIFIORE, FAIR 20b. Place of Disposition (Name of cemetery, crematory or other place) Cremation	ation - City or Town, State
1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) KING MEMORIAL PARK 2-7-2009 BALT	
	TIMORE, MARYLAND
21. Signature of Fineral Service Licensee DONATHAN D. HIBNER. Name and Address of Facility PHILLIPS FUNERAL SERVICE SE	AL HOMÉ, P.A.
1721-27 N. HONROE ST. BABITION	RE, MARYLAND 21217 Approximate
23a. Part /. Et er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate rause (Final	Interval Between Onset and Death
Physician Immediate Cause (Final disease tycondition resulting in death) Amedical Immediate Cause (Final disease tycondition resulting in death) Dun to (or a consequence of consequence	
Examiner Sequentially list conditions by flasher Chalifractione Pulmonary de	sease
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): C	
figure (and in the control of the cause) The cause of the cause in th	
Significant of the property of	
Media Para Media M	
Second S	3d. Date of delivery Month Day Year
1 Yes 2 No 9 Unknown 9 Unknown	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco us	se contribute to the cause of death?
1 Yes 2 1 Yes 2 24a. Was an autonsy	No 3 Probably 4 Unknown
24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of
performed? 1 □ Yes 2 D No	death? 1 □ Yes 2 No
25. Was case referred to medical examiner? 1	Other (Specify)
28a. Date of Injury 28b. Time of 1 28c. Injury at Work?	
1 Natural 5 Pending (Month, Day, Year) Injury Work? 2 Accident investigation 3 Suicide 6 Could not be 28 Place of Injury 4 t home farm street factory office.	
28d. Describe how injury at Work? 1 Natural 2 Pending investigation 3 Suicide 4 Homicide 4 Homicide 5 Pending city or Town, State) 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and building, etc. (Specify) 28f. Time of Injury at Work? 1 Yes 2 No 28f. Location (Street and building, etc. (Specify) 28f. Location (Street and City or Town, State)	Number or Rural Route Number,
	and manner as stated.
29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date	
29c. License number 29d. Date	e signed (Month, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	-05-2007
MARTINA P. CAILYM M.D. DON SCOURS, HOSDITAL 2000 West. BAL	Timore Street
29d. Date State Registrar 29d. Signature and title of certifier 29d. Date 1 29d. Date 1 29d. Date 2 29d. License number 29d. Date 2 29d. Date 1 29d. Dat	

		FOR	State of Marylar				Men	tal Hyg	jiene	0.0	02103
		1 - State Registrar		Cer	tificate of L	Death			eg. 2. C	109	3. Time of Death
Physic		1. Decedent's Name (First, Middle, Last)	COTTE	PELL				Date of Dea Month クタ	Day D1	Year 09	e
/Medi Exami		4a. Facility Name (If not institution, give stre	eet and number)		4b. City, Town, or		ath		4c. Co	ounty of Deal	h
		ST. ELIZABETH	REHABTA	ISG CT	2 BA	If Under 24 Hr	RE	Data of Birth		O Piet	halasa /Stata or Foreign
Funeral		5. Social Security Number 6. Sex 10. No. 10. N	7. Age (In yrs.	last birthday)	Months Days	Hours Mir	n. I (Date of Birth Month, Day	Year)	Conn	hplace (State or Foreign buntry) ecticut
Director		212-28-1193 Usual Residence of Decedent						ug•11;	, 1723	- DOIM	
ba filed within 72 hours after death with the Maryland hal Hygiene. Id other than "natural", or itams 23a or 28a-1 show event, the Madrial Expertment nurst be notified at		10a. Slate 10b. County		ty, Town or Lo							10d. Inside City Limits 1 ☐ Yes 2 ☒ No
Ba-1 s	Funeral Director	Maryland Howard		ETITEOL					10a Citiza	n of What Co	
with the	Dire	10e. Street and Number	070		10f. Zip Code 21043	2			_	SA	outroy:
eath v	erai	4715 Ilkley Moor L	. Was Decedent Ever in L	J.S. 13.1	Was Decedent of H		(Specify	Yes or No-		. Race - Ame	
ifter d	Fun	1 ☐ Never Married 2 ☒ Married	Armed Forces? 1 ☐ Yes 2 🛣 No		lf Yes, specify Cuba 1 □ Yes 2⊠ No		erto Hica	in, etc.)		Black, Whit pec <i>if</i> y: W	
ours a	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:								
natu	iete	15. Decedent's Educa (Specify only highest grade of	completed)	16a. Dece	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of w f)	vorking		16b. Kind	of Business	rindustry
2 should be filed within 72 hours atter death with the Marylan and Mental Hygiene. Is marked other than "natural", or itams 23a or 28a-f show aumstic event, the Madisal Expreries in the notified at	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	1	f Employe					Cateri	ng
i Hyg other	BeC	17. Father's Name (First, Middle, Last)				18. Mother's N			Maiden S	umame)	
should be nd Menta n marked	10 B	Harold Bonney				Florence					
C, Mal y lad y lad y lad y lad 2 should Health and Men tam 27 is marke other traumatic		19a. Informant's Name/Relationship (Type			ng Address (Street						
1 and 1 and 1 eaith 1 eaith 1 eaith 1 eaith		Arthur Roden 20a. Method of Disposition	Son 20b.	Place of Dispo	Ilkley I		Date			ation - City or	
nt of h		1 Burial 2 □ Cremation 3 □ Rec		cemetery, crei	matory or other place w Mem. Pa	ark 2/4	4/20	09	Sykes	ville,	Maryland
permit. Pages 1 and 2 Department of Health a Important: if item 27 is any injury or other tra once.		' 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lipensee		2'	2 Name and Addre	ss of Facility	Ster	ling /	Ashto	n Schw	ab Witzke
Deparim Impo		Verse Kel	MAL	2 1	uneral Ho 630 Edmoi	ndson Av	venu	e: Cai	tonsv	nc. ille,	MD 21228
		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the dea	ath. Do not en	ter the mode of dyir	ng, such as card	liac or re	spiratory ar	rest,		Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition	demer	•							Crisci and Doub
/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):							
		Sequentially list conditions, b.	Due to (or as a conse	quence of):							
uted 1 ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	1+171								
O, exectan an a	Exa	resulting in death) Last	Due to (or as a conse	quence of):							
The COTIAS, P.O. DOX 00/00, The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	licai	d.		-							
A Of entific ding p	Physician/Medi	IF FEMALE: 23	c. If yes, outcome of pregi	nancy			-		23	d. Dale of de	livery
eath cer attendir for use	cian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fe 4 Pregnant at time of	tal death 3	□Ectopic pregnance □ Other (specify)	у				Month	Day Year
the d	nysi	1 Yes 2 WNo 9 Unknown	9□ Unknown								
S, T	by P	Part II. Other significant conditions cont	ributing to death but not re	sulting in the u	underlying cause gr	en in Part I.				/	to the cause of death?
w requires to been signal should be	ted						-	1	Yes 2 €		Probably 4 Unknown
lawr law r las be	ompieted						_	24a. Was autop		24b. Were a prior to death?	utopsy findings available completion of cause of
	O							1 ☐ Yes	2 No	1 □ Ye	
ysicien: The law ysicien: The law is certificate has b director, page 2 s	o Be		ospital: 1 ☐ Inpatient 2	☐ ER/Outpatie	nt 3 DOA Ott	26. Place of I				Other (Sp.	ecify)
Phy rithis ral d	-		28a. Date of Injury (Month, Day Year)	28b. Time of				I. Describe I			
nding Path.	atio	1 ☑Natural 5 ☐ Pending investigation	(Month, Day 1 day	IIIJOTY		Yes 2 □ No					
DIVISION I or Attending after death. Director: Afte	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, st	treet, factory, office		28f	. Location (S City or Tox	Street and wn, State)	Number or F	Rural Route Number,
upital o			ician: To the best of my k	nowledge, dea	th occurred at the ti	me, date and pl	ace, and	due to the	cause(s) a	and manner a	as stated.
To the Hospital or At within 24 hours after of to the Funeral Direct completely filled in by	Medical	(Check only 2 Medical Exemin	er: On the basis of exami and manner stated.	nation and/or i	nvestigation, in my	opinion, death o	ccurred	at the time,	date and	place, and du	e to the cause(s)
To the within To the	Me		2 .0		29c. Licen		_				oth, Dey, Year)
) are ci	2 NP			1615			91	1100	7
121		30. Name and address of person who cor	mpleted cause of death (It	em 23a) (Type	, Print)	HD	213	127			
	State	31. Date filed (Month, Day, Year)	32. Alegistrar's Sig	nature	harles	,		/			
Regis		FFR 0 5 200	19 aneur	A. A	earles						

State of Maryland / Department of Health and Mental Hygiene For State Beg. No. 2 1 1 9 03191 Certificate of Death

Physician /Medica Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at angles. Baltimore, Maryland 21215-0036

FEBRUARY 3, 2009 12:30 a.m.

Physician /Medical Examiner

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be exect Records, P.O. Box 68760 Division of Vital

HELEN DePASQUALE

Be Completed by Funeral Director ၉ Medical Certification: To Be Completed by Physician/Medical Examiner

- negistrai								0.00		00.	00194
1. Decedent's Name		-						2. Date of Dea Month FEBRUA	Day	Year	3. Time of Death 12:30 a ^M
		SQUALE e street and number)		4	4b. City, Town, or	r Location		r EDRUA.		nty of Dea	
	MARIS					IONI					IMORE
5. Social Security N	umber 6. S	ex 7. Age	(In yrs. last bir		If Under 1 Year Months Days	If Unde Hours	r 24 Hrs.	8. Date of Birth (Month, Day	1	9. Bi	rthplace (State or Foreign country)
216-28-	4509	□ M 2 X F	77	Yrs.	violitis Days	nouis			1,193		ARYLAND
Usual Residence of 10a. State	Decedent 10b. County		10c. City, Town	n or Locat	tion						10d. Inside City Limits
		TMODE								1 □ Yes 2 □ No	
MD 10e. Street and Nur		IMORE	BA.	LTIM	10RE 10f. Zip Code			1	10g. Citizen	of What C	
	MPASS R	שמע מעט	. 323						rog. onizon		_
11. Marital Status	MI ASS I	12. Was Decedent E		13. Wa	2122 as Decedent of H	lispanic O	rigin? (Spe	ecify Yes or No-	14.	U.S. Race - Am	A erican Indian,
	ied 2 Married	Armed Forces? 1 ∐Yes 2 🕱N			es, specify Cuba			Rican, etc.)		Black, Whi	te, etc.
3 Widowed		If Yes, Give Year or Dates:		1]Yes 2X∑No	Specify	/ :		Spe	ecify: W	HITE
(Spec	15. Decedent's Ed		16a.	Deceder	nt's Usual Occup and of work done	ation during mo	st of worki	na I	16b. Kind o	f Business	s/Industry
Elementary/Seco		College (1-4or 5-	+)	life. DC	NOT use retired OMESTI	d) -			HOG	PITA	т.
					OMESTI		aor'e Namo	/First Middle			
17. Father's Name (First, Middle, Last) ROBERT Depasquale ALICE DENISE											
	DEPASQI ame/Relationship (10h	Mailing	Address (Street					wn, State	Zip Code)
	IKOLA/	**		•							21237
20a. Method of Dis			20b. Place of	f Disposit	ion (Name of tory or other place)		Date	20c. Locati	on - City o	r Town, State
	Cremation 3 5	Removal from State					2/1/	/00 [2 7 7 77 7	MODE	, MARYLAND
1	service Licer		D.1.1 V	227	Name and Addre	ss of Faci	LIED T	INC DI	17111177 171111	T HO	MARILAND
	La company	0		15	01 EAS	TERN	I AVE	ENUE, BA	ALTO.	MD.	ME 21231
23a, Part 1. Enter t	he disease, or com	plications that caused one cause on each lin	the death. Do							8	Approximate Interval Between
Immediate Cause	(Final	a END STAC		DTC	E A CE						Onset and Death
resulting in death)		a.	a consequence		DEADE						
Sequentially list con	nditions	b									
if any, leading to im cause. Erner Under	mediate	Due to (or as a	a consequence	of):							
Cause (Disease or that initiated events resulting in death) i		C. Due to (or as	a consequence	of):							
, , ,		Due to (or as t	a consequence	01).							
		_d									
IF FEMALE:	t prognant	23c. If yes, outcome							23d	Date of de	elivery
23b. Was deceden in the past 12 1 ☐ Yes 2	months?	1 ☐ Live birth 4 ☐ Pregnant at			Ectopic pregnand Other <i>(specify)</i> _	y				Month	
9 Unknown		9 🗆 Unknown									
Part II. Other signif	ficant conditions of	contributing to death bu	ut not resulting in	n the und	erlying cause giv	en in Part	i I.	23e. Did to	bacco use	contribute	to the cause of death?
								1 □ Y	'es 2□N	o 3□ F	Probably 4X Unknown
								24a. Was a		4b. Were a	autopsy findings available completion of cause of
								perfor	med?	death?	
25. Was case refer examiner?	red to medical					26. Pla	ce of Death	n (Check only o			
1 Yes 2 X	No	Hospital: 1 ☐ Inpatie	nt 2 ER/O	utpatient	3 □ DOA Oth	er: 4 □ I	Nursing Ho	me 5 Resid	lence 6X	Other (Sp	ecify) HOSPICE
27. Manner of Deat	th 5 Pending	28a. Date of Inju (Month, Day	ry 28b. ' <i>y, Year)</i>	Time of Injury	28c. Injul Wor	k?		28d. Describe h	ow injury oc	curred	
2 ☐ Accident 3 ☐ Suicide	investigation 6 ☐ Could not be					Yes 2					
4 ☐ Homicide	determined		iry - At home, fa c. <i>(Specify)</i>	ırm, stree	t, factory, office			City or Tow	Street and N n, State)	umber or F	Rural Route Number,
29a, Certifier	1 Certifying Bl	nysician: To the best	of my knowleds	e death	occurred at the fi	me date	and place	and due to the	cause(s) an	d manner	as stated.
(Check only	2 Medical Exar	niner: On the basis of itioner	examination ar								
29b. Signature and		TUTOHEL			29c. Licens	se number	r		29d. Date ş	gned Mor	nth, Day, Year)
1	SAINA.	SAMP			RI	49	197	_	21	3/7	009
30. Name and add	ress of person who	completed cause of d	eath (Item 23a)	(Type, Pr	int)	111	1		-/-	10	
	JONES, CI				LEY RD.	TIM	ONIUM	, MD 21	093		
31. Date filed (Mon	oth, Day, Year)		ar's Signature					,	~		
ret	0 v a 2009	para	10. Ag	ark							

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month RANCIS DUNNIGAN /Medical February 4a. Facility Name (If not institution, give street and number) **Examiner** The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 **X** M 2 □ F Days 217-38-6114 **Director** 68 Sept6,1940 Maryland Usual Residence of Decedent 10b. County 28a-f show 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director Md. Baltimore City 1 XYes 2 No 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? Funeral 3111 Foster Avenue 21224 filed within 72 hours after death U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1

Yes 2 □ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes, Give þ 1 ☐ Yes 2 X No 3 Widowed 4 Divorced "natural", Specify: White Year or Dates Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Hygiene. Distributor McCormick Allspice . Pages 1 and 2 should be file thent of Health and Mental Hy lant; If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Dunnigan Theresa Helgart 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Dunnigan - wife 3111 Foster Avenue Baltimore, Maryland21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 2-6-2009 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facilit Kaczorowski Funeral Home, PA 1201 Dundalk Avenue Baltimore, 23a. Part 1. Enter the disease, or complications that caused to shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final Physician Myocardial Onset and Death
Z Days disease or condition /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the approximation. use as the burial-transit and Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy Pregnant at time of death Month 5 Other (specify) Dav Year the 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 23e. Did tobacco use contribute to the cause of death? Completed 1 Tyes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy 2 No 1 Yes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence ည 1 X Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) funeral 27. Manner of Death Certification: 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation (Month, Day Year) 2 Accident 1 Yes 2 No 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29b. Signature and the certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

10 x11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

FFR 0 5 2009

RES-000

600 North Wolfe St, Baltimore, MD, 21287

			1- For State of Registrer	Maryland /		artment of H		Mental Hyg	iene 	9 03196			
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	Funeral		1 N7 N 2 0 0	. Age (In yrs. last I		If Under 1 Year Months Days	If Under 24 H Hours M	n. (Month, Day,	Year)	Birthplace (State or Foreign Country)			
	Director		212-46-4074	62	Yrs.			Mar 14,	1946 W	ashington DC			
	and w		Usual Residence of Decedent 10a, State 10b, County	10c. City, To	wn or Lo	cation				10d. Inside City Limits			
	Aaryli sho	ō	MD	Balt						1√2 Yes 2 □ No			
	289-	ect	10e. Street and Number			10f. Zip Code		1	10g. Citizen of What Country?				
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altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "netural; or Items 23s or 28e-f show any injury or other treumetic event, If a Maryleal Examinate and be nutified at ODGs.		21. ignalura of Euneral Service Licensee	lain	22	. Name and Address	s of Facility	rd 655 W.	n 1				
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Вох	leath certifica attending ph I for use as t	√M6	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcomes	ome of pregnancy					23d. Date	of delivery			
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Division of	i i i i	Certification:	4 Homicide determined 289. Place of building	g, etc. (Specify)	iaiii, Stre	et, ractory, office		City or Town	, State)	or Rural Route Number,			
	spite ours nerel filled		29a. Certifier 1 Certifying Physicien: To the b	est of my knowledg	ge. death	occurred at the time	e date and pla	ce, and due to the ca	use(s) and man	ner as stated			
	To the Hospitel or within 24 hours after to the Funerel Direct completely filled in the funerel or the function of the functio	edicai	(Check only 2 Medicel Exeminer: On the bas and manne	is of examination a	and/or inv	estigation, in my opi	inion, death oc	curred at the time, da	ate and place, an	d due to the cause(s)			
	To th Withir To th comp	Ň	29b. Signature and title of certifier			29c. License	number	29	9d. Date signed (Month, Day, Year)			
1			les A Lle so			D312	295		1/29/0	8			
			30. Name and address of person who completed cause	of death (Item 23a) (Type, I	Print)							
			Wandy Kloesz 57	01 KE	NNO	30 y (10	GAL	MORC	no	2/106			
	Sta Registr		30. Name and address of Person who completed cause Line St. Aces 2 5 7 31. Date filed (Mooth, Day, Year) FEB 0 5 2009	gistrar's Signature	Gent	See							
	region	1	LED A O COM Y		70								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Dav Year Nettie G. Elliott 4:55 AM February 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Union Memorial Hospital Baltimore N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) 1 □ M 2 X F Months Days Hours Min 217-12-7977 Director 87 July 30, 1921 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I're Modical Examination. 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits Director Maryland N/A Baltimore XXYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1327 Roland Heights Avenue 21211 IISA Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ∐Yes 2√∑No Specify: Specify: White ģ 3 X Vidowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Seamstress Clothing Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Allan Poe Sophia Harmony 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Jo Wood 4410 Grandview Avenue, Baltimore, Maryland 21211 Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Gardens of Faith 2/6/2009 4 Donation 5 Dother (Specify) Rossville, Maryland 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, Maryland Funeral Service License 21211 umm art1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Arteru Disease oronary days disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Fibrillation Ahial dails Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical F FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Nnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performe 2 MNo 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 Yes 2 No 1 npatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural

hat the death certificate be executed attending physician a for use as the burial-O. Box 68760, ed by the a

Baltimore, Maryland 21215-0036

Medical

2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

(Check only

29b. Signature and title of certifier

Records	The law requires	ate has been sign
Division of Vital Records	The law requires of the Hospital or Attending Physician: The law requires within 24 hours after death.	To the Funeral Director: After this certificate has been sign

State Registrar

ISHRAQUE MD, UNION 31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

☐Could not be

aus han

determined

Darko

MD

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

AT 2438946

MEMORIAL

2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

MD

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HOSPITAL

2009

Please Type or Print in Black Indelible Ink, Ensure All Copies, Are Legible 88 2/20/09 TT Amend 9 11 12 15 16a-b, 17, 18, 19a-b, 20a Pyzzz, Are Legible 88 2/20/09 TT State of Maryland / Department of Health and Mental Hygiene 2009 03198 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year 18:19 PM Alexander Felder 25 2009 TAH /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL BALTIMORE St. AGNES If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Min. Hours 1 € M 2 □ F 53 **Director** 218-62-5242 Jan 5, MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ty∏Yes 2□No Exeminar cast be notified Director MD Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ō 142 S. Hilton Road 21229 USA 23a Funeral items ? unk 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 6 1 ☐Yes 2 📉 No If Yes, Give Year or Dates: Specify. þ Specify: black 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) unk 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation unk (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. Item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Welder unk unk 4 years Centra XANDE 17. Father's Name (First, Middle, Last) 4mk 18. Mother's Name (First, Middle, Maiden Surname) unk Be Pages 1 and 2 should be ပ္ Alexander E. Felder, Sr. Rena Lucille Nowlin 19a, Informant's Name/Relationship (Type. Print)
Chanel Felder (Daughter)
St. Agnes Hospital 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code)
1735 Champlin Dr. Apt E Baltimore, MD 21207
900 CAton Avenue Baltimore, MD 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite 1 ☐ Burial 2 ☐ Removal from State Injury or 4□Donation 5☑Other (Specify) in state Greenmount Baltimore, MD 2/14/2009 22. Name and Address of Facility Vaughn C. 21. Signature of Euneral Service Licensee Ronald S. Wade Virector Greene F.S. Baltimore Nat'l Pike Baltimore, MD 21201 21229 23a. Partit. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate cause (Final disease or condition resulting in death) Physician ENCEPHALOPATHY HEPATIC DAYS /Medical Due to (or as a consequence of): **Examiner** INTESTINAL BLEEDING DAYS JPPER GASTRO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed to hours after death.

Funeral Director: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) o 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by HEPATOCELLULAR 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown CARCINOMA 24b. Were autopsy findings available prior to completion of cause of death? HEPATITIS autopsy performed? 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 은 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1. Natural
2 Accident 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral D

completely filled 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD JAN, 25, 2009 P 23748 MD 21229 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LAJANI JAGANA, St. AGNES HOSPITAL 900 SOUTH CATEN AVENUE, BACTIMORE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

09-00366

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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()		Holy Cross Hospital	,			Silver Spring Montgomery						
Funeral Director		302-88-1125	7. Age ((In yrs. last birth	day) If Under 1 Year Months Day		n.	Co	thplace (State or Foreign untry) MEROON			
any		Usual Residence of Decedent 10a. State 10b. County	11	0c. City, Town o	or Location				10d. Inside City Limits			
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e, MD I and 2 sho Health and item 27 is		JOHN NDANGA/CO	JSIN		808 CONTINE		VE OLNEY	, MARYLAND 20c. Location - City or	20832			
Baltimore, MD 2 permit. Pages 1 and 2 shou Department of Health and Important: If item 27 is raujury or other traumatic		1 X Burial 2 Cremation 4 Donation 5 Other Spe		cremato	ry or other place) Y PLOT	2/1	.3/2009	NDOP, CAME				
Ball permit Depart Impor		21. Signature Funeral Servic-L	censee		22. Name and Addres			KINS FUNER VER, MARYLA				
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/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Myocarditis						Death			
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	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequent	uence of):								
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(C) 😑 😑 o	Physician/Medical	IF FEMALE:	23c. If yes, outcome	of pregnancy				23d. Date of deliver	<u> </u>			
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of Vital Records, 19 Physician: The law require 19 this certificate has been si 19 meral director, page 2 should be	o Be	examiner?	Hospital: 1 Inpatient	i 2 ✓ ER/Ou		Othor:		Residence 6 Othe	r:			
on of tending Pheath. or: After the funeral	-	27. Manner of Death	28a. Date of Injury (Month, Day,Yea	28b. T		ury at Work?	28d. Describe h	ow injury occurred				
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Divis To the Hospital or A within 24 hours after of the Funeral Direct completely filled in by	Medical Co	29a. Certifier 1 Certifying Phy	rsician: To the best of my liner:On the basis of exami	knowledge, dea nation and/or in	th occurred at the time, overtigation, in my opinion	date and place, ar on, death occurred	nd due to the cause at the time, date a	e(s) and manner as statenders, and place, and due to the	ed. ne cause(s)			
To wit To	Mec	29b. Signature and title of certifier	and manner stated.		29c. Licer	nse number		29d. Date signed (Mo	nth, Day, Year)			
		Caral	Halla	~	0.0	.M.E.		January 14, 200	9			
3			ho completed cause of deastant Medical Exami	,	Penn Street, Baltin	nore, MD 212	01					
S Regis		31. Date filed (Mortin, Day, Year)	32. Registrar's	Signature	backer							
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DHMH 17 Rev 1/2001 OCME 2006

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Amend PI line a-b, 25 perME, 8889, 3/18/09 TT
State of Maryland'/ Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day / 29 Month Year **Physician** FIDDLE 1030 PM MORRIS ANUM 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NORTHWEST HOSPITAL CENTER RANDALLSTOWN BALTIMORE 6. Sex 1 X M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06/06/1923 Birthplace (State or Foreign Country)
 MD **Funeral** Days Min. Months Hours 219-16-3205 85 **Director** Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10h. County show ms 23a or 28a-f shor 1 ☐ Yes 2 No Director MD BALTIMORE BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2437 SYLVALE ROAD Funeral 21209 USA death 1 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any Injury or other traumatic event, the Medical Examinator. 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No WHITE Specify. Specify: à 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) ACCOUNTANT ACCOUNTING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be FIDDLE RIFKOVITZ JULIUS ANNA ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4001 OLD COURT RD., #509, PIKESVILLE, MD JOAN FIDDLE / WIFE 21208 altimore. 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition LUBAWTTZMWUSACHP NER TAMID 1 💢 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Dother (Specify) 02/01/2009 ROSEDALE, MD 21. Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Intracerebral hemorrhage Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** INTRACKANIAL BLEEDING disease or condition resulting in death) /Medical Examiner Atherosclerotic cardiovascular disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last CENTER HON APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burlar-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an autopsy perform 1 □Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 1445931 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smith Nonio sute 203 Baltimore MD 2120 Burton 2835

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

FEB 0

5 2009

ORIGINAL

Barker

32. Registrar's Signature

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			For State Registrar	State of Marylar		nte of Death	Reg. N	with the site	0 02201
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- 100	Physici /Medic	al	Bernice	Carol 1	slenn	y Town or Location of Dooth	FEb. 4	1 2009	
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	Funeral		5. Social Security Number 6. Se			er 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Yea	9. Birt	thplace (State or Foreign
	Director		Usual Residence of Decedent	4	c Tis.		Van 10,1	443 500	ith Carolina
	show	_	10a. State 10b. County	10c. Ci	ty, Town or Location		·		10d. Inside City Limits 1 ☑Yes 2 ☐ No
	the Ma 28a-f	recto	10e. Street and Number	+ 1	Saltima	Cip Code	10a. (Citizen of What Co	
	h with	Funeral Director	4511 Kathle	and Ave	2	21207		USA	ŕ
	tems 2	uner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13. Was Dec	edent of Hispanic Origin? (Specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
336	be filed within 72 hours after death with the Maryland tial Hyglene. do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	₽	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ∐Yes 2 ☐ M6 If Yes, Give Year or Dates:	1 □ Yes	2 No Specify:		Specify: P	black
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Mar	S S S		19a. Informant's Name/Relationship (7) Terri Mason -	rpe. Print)	19b. Mailing Addre	ss (Street and Number or Rur	y Blvcl	or Town, State, 2	Zip Code) MD 31215
re,	es 1 and 2 of Health fitem 27	3	20a. Method of Disposition	20b.	Place of Disposition (N	ame of		Location - City or	Town, State
Baltimore,	Pages Iment of tant: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State	and laws	emetery Feb.	10,2009 B	altimac	MD
Ball	permit. Pages Department or Important: If I any injury or once.		21. Si ma un of Funeral Service Licens	thwill.	22. Name	and Address Facility	well Fu	neral	MD 21207
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S, F	es that igned I be det		Part II. Other significant conditions co	-	sulting in the underlying	cause given in Part I.	×1		the cause of death?
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of Vital	ilan: T ertificat ctor, pe	Be C	25. Was case referred to medical examiner?			26. Place of Deat	1 □ Yes 2 🙉 th (Check only one)	No 1 □Yes	3 2 □No
of V	Physic this ce al dire	၉	1 Yes 2 XNo 27. Manner of Death		ER/Outpatient 3 28b. Time of		ome 5 Residence		ecify)
O	th. : After	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how in	jury occurred	
Division	r Atter ter dea rector	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, factorify)	ory, office	28f. Location (Street City or Town, Sta	and Number or Rate)	ural Route Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 Certifying Phy	1		ed at the time, date and place,	and due to the cause	e(s) and manner a	s stated.
	ne Hos n 24 ho ne Fun pletely	Medical				on, in my opinion, death occur			
	Vithii Vorug	Ň	29b. Signature and title of certifier		2	9c. License number AS243852	29d. 1	Date signed (Mont	th, Day, Year)
			30. Name and address of person who of	ompleted cause of death (Ite	m 02a) (Time Print)				
7) V		MUHAMMAD	SARWAR.	- 51. Agne	s Hospital	900 Coton.	Ave. Bu	Itimere, mD.
	Sta Registi		31. Date filed (Month, Day, Year)	32 Registrar's Sign	ature 0				
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			For State Registrar	State of Mai	ryland / I		tificate of D			Reg. N	200	9 03	202
	Physicia	an	1. Decedent's Name (First, Middle, Catherine	Last)		Gau	ghan		2. Date of De Januar		. 200g	3. Time of 2:37	f Death DM
	/Medic		4a. Facility Name (If not institution,				4b. City, Town, or	Location of Death			c. County of Dea		
	Examin	GI.	Genesis Hamilt	on Nursing Co	enter_		Baltimor				N/A		
ı	Funeral Director		218-07-2030	6. Sex 7. Age 7. Age 9((In yrs. last bi	rthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Jan. 4	ay, Year) . C	irthplace (State Country) ryland	or Foreign
	ow ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Lo	cation					10d. Inside (
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	To the within To the comp	Me	29b. Signature and title of certifier	<u></u>	and the second	n	29c. Licens	e number		29d. l	Date signed (Mo	onth, Day, Year)	
	1		30. Name and address of person	who completed cause of de	eath (Item 23a) (Type.	Print)						
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	Sta Registi		31. Date filed (Month, Day, Year)	5 2009 A September 5	CAL A	9. 19	barks						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year Samuel A. Hearn 2009 :50P /Medical 11 anuary Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death BALTIMORE Pirthnlace (State or Foreign GREATER BALTIMORE MEDICAL CENTER Social Security Number If Under 1 Year 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, 9. Birthplace Country) Funeral Days 1 M 2 □ F Months Hours Min 80 Director 220-24-1494 Jan 24, 1929 Ohio Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show the Medical Evaminer must be notified at MD Director Baltimore Ruxton 1 □Yes 2√□No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1712 Killington Road 21204 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No 9 Specify 3 Widowed 4 Divorced Specify: white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2 should be filed within and Mental Hygiene. attorney lega1 7 Is marked other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Simpson Hearn Carmelita Cunningham မ Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health a Important: If item 27 Is any Injury or other trau Mary Lou Hearn/spouse 1712 Killington Road Ruxton, MD21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Euneval Service License Ronald S 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** - HADNIC OBSTRUC 1 SeA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ੬ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy 2 KN 1 □ Yes Attending Physician: To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2,2 Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) ဂ္ 1 ☐ Yes 1 opatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

State Registrar

Medical

31. Date filed (Month, Day,

29a. Certifier

(Check only

29b. Signature and title of certifier

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

ame and address of person who completed cause death (Item 23a) (Type, Print)

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NOEROCHARLES 6565 street

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 2, 2009 **Physician** George F. Hallameyer, Jr. 11:23 AMM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Kris Leigh Assisted Living Center Severna Park Anne Arundel 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Mary Tand 214-24-8898 1 M 2□ F 80 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Examples and the notified at 1 ☐ Yes 2 No Maryland Anne Arundel Severna Park 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21146 United States 831 Ritchie Highway Unit 305 Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armer Forces? 1∌Yes 2□No ffYes, Give Year or Dates: Korean 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No altimore, Maryland 21215-0036 Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, In M. Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Computer Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George F. Hallameyer, Sr. Frances Weber 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa Hughes / Daughter 630 Douglas Street Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 02/04/2009 Baltimore, Maryland 4 Donation 22. Name and Address of Facility David J. Weber Funeral Homes PA ignature of Funeral Service I/cense 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause the each line. 5311 Edmondson Avenue Baltimore, MD 21229 Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical attending p IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was ar certificate has breeze, page 2 s autopsy performed? Ves 2 No 1 ☐ Yes 2 1 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manny of Death funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation ours after death.

neral Director: Af
filled in by the fur 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral C 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated To the 29b. Signature and

Registrar
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Physicia Vedical Exami	an/	Decedent's Name (First, Midd Robert	le,Last)	Hood	-					Date of De Month ebruary		Year		3. Time of Death 1835 hrs
		4a Facility Name (if not instituted 1314 Scottsdale Road					y, Town, or Li I Air	ocation of	Death		- 1	Counly of arford	Death	
Funeral Director	zh.	5 Social Security Number 217~86~7064		Age (In yrs. lasi	0	Mo	nder 1 Year	If Under Hours	Min				Foreign	iplace (State or
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21215-0036 wild be filed within 7 Mental Hygiene marked other than c event, the Medica	Be	Robert S. Hood		•			F	Evely	n G.	G. Cashner				
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Baltimo permit. Page Department of Important: injury or ott		1/Signature of Funeral Service Hoensee Without Service Hoensee 22 Name and Address of Facility Connectly Funeral Home Of Di 7110 Sollers Point Road, Di											P.A	21222
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Physical directions	၉	1 Yes 2 No 27 Manner of Death	ı ınpa	L., J	R/Outpatier 8b. Time of	L	DOA 28c Injury		Nursing F	d Describe		nce 6 🗸		Scene
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To the Hospi within 24 hou To the Funes	Medical C	29a Certifier (Check only 1 Certifying P	Physician: To the best of aminer: On the basis of e	kamination and										
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State of Maryland / Department of Health and Mental Hygiene 03206 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 9:40A.M Dallis Martin Holden plomary 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Baltimore Washington Medical Center Glen Burnie If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral 1 1 M 2 □ F Months Days Hours Min 89 213-30-8664 11/15/1919 Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examinar must be notified at once. 1 ☐ Yes 2X No Director MD Anne Arundel Glen Burnie 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 102 N. Crain Hwy, 21061 U.S.A. Apt. 940 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ₹ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: black If Yes, Give Year or Dates: 1 ☐ Yes 2 No ģ Specify: 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Trucking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ William Holden Flossie Roberts 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 228 Michele Circle; Millersville, MD 21108 Mrs.Doris Anderson / niece 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 2/05/2009 Atlantic Crematory Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign: ture of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation Services, PA; 1 2nd Ave SW; Glen Burnie, MD21061 23a. Part 1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ceuse (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physiclan and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No certificate has been signed by the irector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a Was en autopsy performed res 200 No ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl o e) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes npatient Medical Certification: To 2 ER/Outpatient 3 DOA Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28a. 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. the 29b. Signature and title of certifier 2 29d. Date signed (Month, Day, Year) MU person who completed cause of reath (Item 23a) (Type, Print) 301 Degistrar's State 2009 5 Barken. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month :15 am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Joseph Richey Hospice If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Min. 1 □ M 2 🛛 F Months Hours 49 14, 102-64-6591 Director Aug 1959 Nigeria Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show r than "natural", or items 23a or 28a-f sho the Medical Examiner court be notified at MD Director Baltimore tyCYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5009 Frankfort Avenue 21206 Funeral Nigeria 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. , o. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: 2 Specify: black 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other than 'any injury or other traumatic event, the Mones. Elementary/Secondary (0-12) College (1-4or 5+) 12 5+ pastor religion 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Jumbo Mary Peters 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chichi Nwofor/friend 7212 Oak Haven Circle Baltimore, MD 21244 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 3 Removal from State 1 ☐ Burial 2 ☐ Cremation 4□Donation 5 Mother (Specify) in state 21. Signature of Funeral Service Lie State Anatomy Board 655 W. Baltimore Street Wade Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** audioniu disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) sician and burial-trans Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical as the IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Ye ar 4 ☐ Pregnant at time of death 5 Other (specify) ed by the a 9 D Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should has been 24a. Was an Were autopsy findings available prior to completion of cause of death? autopsy performed certificate 2 No 1 🗆 Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Author (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 24 hours after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Records, P.O. umpo Vital Division of To the

Maryland 21215-0036

Baltimore,

State Registrar

completely

within 2

Medical

4 Homicide

(Check only one)

31. Date filed (Month, Day,

29b. Signature and title of certifier

29a. Certifier

determined

Year)

and manner stated.

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

racke

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 19a & 19b, per Fh 8888 2/10/09 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 10:10PM **Physician** ounson 02,2009 ebruary /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Nursing Bu izabeth enter timov 8. Date of Birth Feb. 18, (In yrs. last birthday) If Under 24 Hrs. If Under 1 Year 9. Birthplace (State or Foreign 6. Sex **Funeral** Min Year 932 Days Pennsylvania 1 □ M 2**X**) F 183-24-6866 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show be notified at 1 XYes 2 ☐ No MD N/A Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 2 and 1 injury or other traumatic event, the "Middel Event har must be note. 21229 3200 Benson Avenue United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) UNK. 16b. Kind of Business/Industry しいに. Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Paul Edward Billick Helen Marie Voss ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6241 Latch Lift Court, Elkridge, MD 21075 19a. Informant's Name/Relationship (Type. Print) Howard L. Johnson, Jr. / Son 20b. Place of Disposition (Name of cemetery crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Atlantic Crematory 2-4-2009 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signa ure al Funeral Service Lie 1328 Sulphur Spring Rd., Arbutus, MD 21227 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician V-ears disease or condition resulting in death) /Medical Due to (or as a consequence of): mellitus Examiner a Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 No 3 Ectopic pregnancy Ye ar Day 5 ☐ Other (specify) signed by the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate ha 1 ☐ Yes 2 ☐ No 2 **X** No 1 □Yes this certific al director, 25. Was case referred to medica examiner? 26. Place of Death (Check only one Be 1 Yes 2 No Hospital: Other: 4 Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 2 Accident 5 Pending investigation 1 □Yes 2 □ No death. within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Benson Min timore 20 32. Redistrar's Signature 31. Date filed (Month, Day, Year) State 5 2009 FEB 0 Registrar

Jong Hoo Kim State of Maryland / Department of Health a Certificate of Death								0.0	20.000		
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)	·	incate of	Death	14 19 1	2. Date of Dea		3. Time of Death		
Medical Exami		Jong Hoo	Kim				Month January 2	Day Year 29, 2009	0938 hrs		
5		4a. Facility Name (if not institution, give 6000 Same Voyage Way #			4b. City, Town, or L Clarksville	ocation of Death		4c. County of Death Howard			
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year	If-Under 24Hr		Birthplace (State or			
Director			1 2 F	56 Yrs	Months Days	Hours Mir	Nov		Country) Kirea		
		Usual Residence of Decedent					1.40				
ow any		10a. State 10b. County	1	Town or Locat		2			10d. Inside City Limits 1 Yes 2 No		
ryland a-f sh	ctor	MI) Howar		JIGI	10f. Zip Code			10g. Citizen of What Co			
he Ma ror 28 iffed a	Director	6000 Same V	wase way	#207	211	129		USE	7		
ı with the Maryland ms 23a or 28a-f show be noiffied at once,		11. Marital Status	12. Was Decedent Ever in U.S		as Decedent of Hisp es, specify Cuban,			o- 14. Race - Am White, etc	erican Indian, Black,		
r death or ite	Funeral	1 Never Married 2 Married	Armed Forces? 1 Yes 2 No				o Ricall, etc.)		cion		
rs afte	<u>۾</u>	Widowed 4 Divorced 15. Decedent's Education (Specify only)	f Yes, Give Year or Dates: (highest grade completed)	16a. Deceder	Yes 2 No	specify: on (Give kind of	work done	Specify: 1-1	S/Industry		
72 hou n "nat al Exa	eted	Elementary/Secondary (0-12)	College (1-4 or 5+)		nost of working life.	DO NOT use re		1			
5-0036 led within 72 hours a Hygiene. other than "natural the Medical Examin	Completed	12		Con	tracte			100,00	uction		
15-00 filed wit all Hygien ed other	Be Co	17. Father's Name (First, Middle, Last)	20		1	8.Mother's Nam	ne (First, Middle,	Maiden Surname)			
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-fate and a second, the Medical Examiner must be notified at once	S B	19a. Informant's Name/Relationship (Ty	oe, Print),	19b. Mailin	g Address (Street	and Number or	Rural Route Nu	umber, City or Town, St	ate, Zip Code)		
e, MD 21215-00. I and 2 should be filed with Health and Mental Hygiene item 27 is marked other ur traumatic event, the Mes		Dennis Kin	n. brother	6810	o Cree	KWOOZI	, Clar	Ksville, 1	1D 21029		
nore, ME ages I and 2 s mt of Health at it: If item 27		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	crematory or of	sition (Name of cerr ther place)	netery,	Date	20c. Location - City			
도 집 의 둘 닭 1		4 Donation 5 Other Specify:		etro	Cremeto Name and Address		13/09	Control	nere, MI)		
Balti permit. Departn Import		21/3 n ure of Funeral Service Licens	Howell	// ic	270 Ga	Lilton	swell	Furabal	Horse MD 20194		
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/Medical Examiner	0.8	Immediate Cause (Final disease a. F	therosclerotic Cardiov	ascular Dis	sease			_14	Death.		
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	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	ue to (or as a consequence of	f):		100			76.70		
	Examiner	(Disease or injury that initiated C	ue to (or as a consequence of	f):							
executed an and al - transit		d									
D, be es	edical	UNPENDED	AMENDED				_				
6876(certificate iding phy	an/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregr		etal death 3	23d. Date of delivery death 3 Ectopic pregnancy Month Day Year					
Box 6 e death cer the attendi	Sic	past 12 months? 1 Yes 2 No 9 Unknown	4 Pregnant at time of de	ath 5 C	other (Specify)						
Records, P.O. Box 68766 The law requires that the death certificate cate has been signed by the attending phy page 2 should be detached for use as the b.	Phy	Part II. Other significant conditions	g Unknown contributing to death but not re	esulting in the	underlying cause g	iven in Part I.	23e. Did	tobacco use contribute	e to the cause of death?		
ires that the signed by t	þ		<u>-</u>	-			1 _ Y	'es 2 No 3	Probably 4 V Unknown		
Records, The law requir ficate has been s	Completed	*					24a. Wa		e autopsy findings available to completion of cause of		
eco he law ate has	отр					-	per	formed? deatl			
	Be C	25. Was case referred to medical examiner?				of Death (Chec	k only one)				
Sion of Vital Rec Attending Physician: The r death. ector: After this certificate by the funeral director, page	70	1 ✓ Yes 2 No 27. Manner of Death	ospital: 1 Inpatient 2	ER/Outpatier 28b. Time of	10 501.	Other 4 Nurs	sing Home 5	Residence 6 O e how injury occurred	ther: Scene		
		1 Natural 5 Pending	28a. Date of Injury (Month, Day,Year)	200. Timle of		res 2 No	200. Describ	e now injury occurred			
Division tal or Attendi rs after death. al Director: A	ficat	2 Accident Investigation	28e Place of Injury - At he	ome, farm, str	eet, factory, office b	uilding, etc.			Rural Route Number, City		
Divi	Certification:	3 Suicide 6 Could not be determined					or Town	, State)			
Division To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the I		29a. Certifier 1 Certifying Physicia (Check only one) 2 Medical Examiner:	n: To the best of my knowled On the basis of examination a	ge, death occi	urred at the time, da	ite and place, a	nd due to the ca	nuse(s) and manner as	stated.		
To the within To the comp	Medical	29b. Signature and title of certifier	and manner stated.		29c. Licens			29d. Date signed			
-	=	(C) _ IVT):	Limo		0.0.1			February 2, 20			
Th J		30. Name and address of person who c		n 23a)					-		
	8 8		Assistant Medical Exar		1 Penn Street,	Baltimore,	MD 21201				
S Regis		31. Date filed (Month, Day, Year) FEB 0 5 20	32. Fegistrar's Signati	ure.	all						
regis	oren.	I LU V U ZU	10 1	- 44							

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 9 03210 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year February 3, 2009 **Physician** 10:10 PM Dolores C. Kowaleski /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Riverview Care Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 X F Months Days Hours 81 11/25/1927 Maryland Director 219-30-9275 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show la or 28a-f show Director 1 Yes 2 □ No Baltimore Maryland N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21231 United States 1752 Bank Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after thealth and Mental Hygiene. em 27 is marked other than "natural". or iter 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Domestic ed other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Adam J. Kowaleski Veronica Gruna 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1752 Bank Street Baltimore, Maryland 21231 Theresa Kowaleska - Sister 20b. Place of Disposition (Name of cemetery, crematory or other places Saint Stanislaus 20a. Method of Disposition 20c. Location - City or Town, State 1 \ Burial 2 \ Cremation 3 \ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 02/07/2009 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
David J. Weber Funeral Homes P.A. 401 S. Chester Street Baltimore, Maryland 21231 rart 1. Enter the disease, or complica shock, or heart failure. List only one ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cancer /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 non 3 🗆 Ectopic pregnancy Month 5 Other (specify) 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Winknown Certification: To Be

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760. P.0. Records, Division of Vital To the Hosp within 24 hou To the Fune completely fi

		24a. Was an autopsy performed? 1						
25. Was case referred to medical examiner?	26. Place of Death (Check only one)							
1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Nursing Hor	me 5 ☐ Residence 6 ☐ Other (Specify)						
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred						
3 Suicide 6 Could not b 4 Homicide determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	hysician: To the best of my knowledge, death occurred at the time, date and place, miner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.							

29c. License number

D0061907

29d. Date signed (Month, Day, Year)

State Registrar

Medical

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Ebo 1124 Mace Avenue Essex, Maryland
31. Date filed (Month, Dgy, Year) 32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 05 PM Kempa Mae Ivadell 2 2009 FERRUARY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE
If Under 1 Year | If Under 24 Hrs. JOHNS HOPKINS BAYVIEW MEDICAL CENTER 8. Date of Birth (Month, Day, AUGUST 6, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Months 1 M 2 KF West Virginia 233-66-3897 64 Director Usual Residence of Decedent Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Mactical Examiner must be notified at once. 1 □Yes 2 XNo Director Baltimore Dundalk Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21222 USA 1739 Drexel Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 🔏No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🛚 No Specify. þ Specify: White 3 XWidowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 11 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Julie Richardson Aldar Kulchar ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1739 Drexel Road, Dundalk, Maryland 21222 Robert Kempa Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition February 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Bayview Crematory Baltimore City, MD. 4, 2009 4 ☐ Donation 5 ☐ Other (Specify) Connelly Funeral Home Of Dundalk, P.A. 46 nie 7110 Sollers Point Road, Dundalk, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** METASTATIC - moint HS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 D Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 KNo Month Day Year 5 ☐ Other (specify) the 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has 1 ☐ Yes 2 🗷 No Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 SInpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation 1 □Yes 2 Accident after death Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral D 29a. Certifier 1 🗷 CertifyIng Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ASK 4940 EASTERN AVENUE FRED 31. Date filed (Month, Day, 32. R gistrar's Signature State Registrar

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

Funeral Director

		State of Maryland		rtment of F			iene			
•	1 - For State Registrar	otate of Maryland	-	tificate of		, ,	eg. No. 2009	03212		
an	Decedent's Name (First, Middle, Last)					2. Date of Deat	h Day Year	3. Time of Death		
al	Mary E.	Lauenstein				02	04 2000	UT52 AM		
er	4a. Facility Name (If not institution, give	street and number)	_	4b. City, Town, o	r Location of Death		4c. County of Dea	ath		
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	213-03-0044	7. Age (In yrs. las	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, July &	3,1921 9. Bi	rthplace (State or Foreign Country) MD		
	Usual Residence of Decedent 10a. State 10b. County	10c. City.	Town or Loc	cation				10d. Inside City Limits		
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Be Completed by Funeral Director	10e. Street and Number 8810 Walter B		10f. Zip Code	21234	0g. Citizen of What C	ountry?				
ner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. V	3. Was Decedent of Hispanic Origin? (Sport of Yes, specify Cuban, Mexican, Puerto		pecify Yes or No-	14. Race - Am			
F	1 ☐ Never Married 2 ☐ Married	1 ⊟Yes 2 XNo		l □Yes 2√2 No	Specify:	o riloan, etc.)	Black, Whi			
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ပိ	12th 17. Father's Name (First, Middle, Last)			-	19 Mother's New	o (First Middle II	(First, Middle, Maiden Surname)			
Be	David A. Mess	engor					vialueri Surname)			
ဥ						e Earl				
	19a. Informant's Name/Relationship (Ty			•			r, City or Town, State,			
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	20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ P	cem	netery, cřen	natory or other pla			•	,		
	4 ☐ Donation 5 ☐ Other (Specify)				ery 2/7	709	Baltimor	e MD		
	21. Strature Junezal Service License 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221									
	23a. Part 1. Enter the disease, o compli	ications that caused the death.						Approximate Interval Between		
	23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final									
	disease or condition resulting in death) a. Atherosclerotic Viscolicy Disease Due to (or as a consequence of):									
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Examiner	Sequentially list conditions, if all y, is a unit of the conditions of the condition									
	resulting in death) Last	Due to (or as a consequer	nce of):							
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IF FEMALE: 23c. If yes, outcome of pregnancy 1								death?		
3e (25. Was case referred to medical examiner?				26. Place of Dea	th (Check only on	e)			
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ü	27. Manner of Death N☑ Natural 5 ☐ Pending	28a. Date of Injury 28 (Month, Day, Year)	8b. Time of Injury	28c. Injui Wor	y at k?	28d. Describe ho	d. Describe how injury occurred			
cati	2 ☐ Accident investigation	M 1 □Yes 2 □			Yes 2 ☐ No	2 No				
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-	29b. Signature and title of certifier	400		29c. Licens		2	9d. Date signed (Mor	/		
	heler 1x	the po			055992		02/04	107		
	30. Name and address of person who co	1 - 1 - 11			2 - 11	* • •				
	1) e borch C. 6a11			d Ave	BAltimore	MD	21222	11		
te	31. Date filed (Month, Day, Year)	32. Registrar's Signatur	to have to	1.1						

12

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death < NIGHT Day 200°9 **Physician** 010AM 31 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ALTIMORE SP TUAR If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months 1 3 M 2 □ F 6400 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evaning must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Layes 2 □ No **Funeral Director** MLD Daltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2121 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 2 🗆 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ M6 Specify ò 100 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Toller 2 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be ೨ Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mother Madusor 21211 HIMBLE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Dispositien 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Domation 5 ☐ Other (Specify) altimore 21. Signature of Funeral Service Licensee well Funeral Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the aftending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, è 1 Nes 2 □ No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy Were autopsy findings available prior to completion of cause of performe death? 1 ☐ Yes 2 **☑** No 1 Yes 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day, Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 □ No 2 Accident Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month, Day,

Year)

5

FEB 0

32. Registras's Signature

09-00865 James McCoy

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

,		1- For State Registrar Certif	ificate of De	eath	nomal my	Reo	, No. 200	9 0321
Physicia	n/	Decedent's Name (First, Middle,Last)			AFI	2. Date of Death	Day Year	3. Time of Death
Medical Examir		JAMES McCOY		· -		January 29	, 2009 4c. County of Death	1245 hrs
		Facility Name (if not institution, give street and number) Poplar Grove Street		ity, Town, or Loca altimore	ation of Death			
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las			f Under 24Hrs.	8. Date of Birth	N/A (MM/DD/YYYY) 9. Bir	thplace (State or
Director		215 06 2000	M	lonths Days	Hours . Min.	09/29/	Foreign MARYLAND	
	ŀ	215-86-3808				1 09/29/	1902	
v any		10a. State 10b. County 10c. City, T	own or Location					10d. Inside City Limits
Aaryland 28a-f show any Latonce.	ē	MARYLAND N/A	BALTIMO					1 XXYes 2 No
e Mary or 28a- fied at	Director	10e. Street and Number	101	f. Zip Code		10	g. Citizen of What Cou	ntry?
ith the 23a o	- 1	2907 BRIGHTON STREET	140 W = D	2121	-	- aif . V- a - a Na	U.S.A.	ican Indian, Black,
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at once	Funeral	11. Marital Status 12. Was Decedent Ever in U.S 1 XNever Married 2 Married Armed Forces?		cedent of Hispan pecify Cuban, Me			White, etc.	cari indian, biack,
		3 Widowed 4 Divorced If Yes 2 XX No	1 Yes	ZXX No sp	oecify:		Specify: BLA	.CK
ours a atura	d b	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's U				16b. Kind of Business/	Industry
6 172 h an "n cal E	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		of working life. DC	NOT use rear	eu)		
5-0036 ited within 72 Hygiene.	E.	10th grade	PLUMBE		Anthor's Namo	/Eirot Maddlo M	CONSTRUC	TION
21215-0036 and be filed within 7 Mental Hygiene. marked other than e event, the Medica	Be	in the second se						
T poer		WILLIE MCKOY 19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Add			L ROBERT tural Route Number	oer, City or Town, State	e, Zip Code)
MD and 2 should be an and 1 should be an and 1 should be an and 1 should be an		BRENDAL McKOY/ Mother	2907 1	BRIGHTON	ST., 1	BALTIMOR	RE, MARYLAN	D 21216
re, s I and f Heal ff item			ace of Disposition ematory or other p		ery,	Date	20c. Location - City of	Town, State
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. International forms 27 is marked other than "natural", or other transmatic event, the Medical Examine.			NG MEMOR	IAL PARK	02	-06-09	BALTIMORE,	MARYLAND
Baltimore, MD 2 pemit. Pages I and 2 shoul Department of Health and M Important: If iren 27 is m injury or other transmatic		21. Signature of Fundal Service Lense e	22. Name WIL	and Address of LIAM C B	Facility ROWN CO	OMMUNITY	FUNERAL H	OME P.A.
		23a. Part I. Enter the disease, or complications that caused the death. I	120	6 W NORT	'H AVEN	JE		Approximate Interval
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and - trans	edical	d						
760, icate be executed physician and the burial - transit		UNPENDED AMENDED					100:0: (
876 tificate ng phy as the		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnant 1 Live birth	ancy ₂ Fetal d	eath 3	Ectopic pregna	ncy	23d. Date of delive Month	ry Day Year
Box 68's death certiff	sician/	past 12 months? 4 Pregnant at time of dea	46	(Specify)				
. BC he dea y the a	Phys	Part II. Other significant conditions contributing to death but not res	sulting in the unde	duina sauco sivo	n in Part (23e Did to	bacco use contribute to	the cause of death?
i, P.O. B ires that the d signed by the		Part II. Other significant conditions Continuing to death but not res	suring in the unde	ilyilig cause give	at iii rait i.			obably 4 Unknown
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of Vital Records, R Physician: The law require wher this certificate has been si meral director, page 2 should	o Be	examiner?	ER/Outpatient 3		205.		Residence 6 V Other	er: Scene
1 of V	-1	27 Manner of Death 28a Date of Injury	28b. Time of Injury	y 28c. Injury a	at Work?		now injury occurred	
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Division piral or Attendir ours after death teral Director: A	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At hor		actory, office build		or Town, St	tate)	tural Route Number, City
Divisior Hospital or Attent 24 hours after death Funeral Director:	Cer	4 Homicide determined (Specify) Other (garage) 900 Poplar Grove Street, Baltimore, MD						
Division of Vital Records, P.O. Box 68760, vithe Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)						
To the within To the comple	Med	and manner stated. 29b. Signature and title of certifier		29c. License n			29d. Date signed (M	
		Laboret Therthall MA		O.C.M.	Ę.		January 30, 200)9
		30. Name and address of person who completed cause of death (Item 23a)						
9		Pamela E. Southall, MD Assistant Medical Exan		enn Street, E	Baltimore, N	/ID 21201		
St Regist			1. bar	. 1				
		1 LU V O COUD TARRELL P						
DHMH 17 Rev 1/20	JU I		ORIGINAL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TITEM#7,800 FFH G888 of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 2, Stanley S. Manowski February 2009 8:30 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Stella Maris Hospice Dulaney Valley If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 0-24-19179. Birthplace (State or Foreign (Month, Day, Vear) **Funeral** 1 XM 2 □ F -84 - 91217-09-9388 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f shany injury or other traumatic event, Its Phylical Evantural must be notified. Director 1X Yes 2 ☐ No N/A Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 601 S. Streeper Street 21224 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 1941–45 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify. Specify: White ⋛ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Stevedore Tuqboats 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stephen Manowski Pauline Unknown ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gerard S. Manowski - Son 18 Hurst Court Nottingham, Maryland 21236 20b. Place of Disposition (Name of cemetery crematory or other place)
Saint Stanislaus
Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Pages ' 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 02/06/2009 Baltimore, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
David J. Weber Funeral Homes P.A. 21. Signature of Funeral Service Licensee 401 S. Chester Street Baltimore, Maryland 21231 Pay 1. Enter the disease, or con plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List cold one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CONGESTIVE HEART FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) the detached 9 Unknown 2 been signed the should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 X Other (Specify) **HOSPICE** 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending investigation or Attending 1 Natural 2 Accident Injury death. 1 ☐ Yes 2 ☐ No by the 1 within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and Nurse Practitioner. Nurse Practitioner.

Division of Vital Records, P.O. STANLEY MANOWSKI

21215-0036

Maryland

Baltimore, EBRUARY

2,

To the Hospital completely

Registrar

29b. Signature and title of

31. Date filed-(Month, Day, Year)

0 5 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JONES,

CRNP 2300 DULANEY VALLEY RD.

32. Registrar's Signature

29c. License number

TIMONIUM, MD 21093

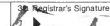
29d. Date signed (Month, Day, Year)

			1 - For Stata Registrar	State of Maryl			of Health and I		ne No2009	03216	
Physici /Medic Examin		cal	1. Decedent's Name (First, Middle, Last) Maragret McIaman 4a. Facility Name (If not institution, give street and number) 715 Maiden Choice Lane CC 105 Catonsyille						th Day Year 2 09 4:12 A		
	Funeral Director		715 Maiden Choice 5. Social Security Number 207-20-0268 Usual Residence of Decedent	Dane oo 10.	yrs. last birthday) Yrs.	If Under 1 Y	.0110 (11110	8. Date of Birth	Baltimor 9. Birth 1929 Peni	place (State or Foreign ntry) nsylvania	
ind 2	the Maryland 288-f show	To Be Completed by Funeral Director	10a. State 10b. County Maryland Baltimor 10e. Street and Number		. City, Town or Lo		de			10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
	be filed within 72 hours after death with the Marylan tal Hygiene. Id other than "netural", or items 23a or 28a-f show other than "netural", or items 23a or 28a-f show event, it a Madical Examiner must be notified a		715 Maiden Choice 11. Marital Status 1 Never Married 2 Married 3 Midowed 4 Divorced	12. Was Decedent Ever i Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give		Was Decedent	of Hispanic Origin? (S Cuban, Mexican, Puert	pecify Yes or No-	USA 14. Race - Ameri Black, White,	can Indian,	
	I within 72 hours iene. r than "netural", ir e Madical Ext		15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12)		(Give	dent's Usual O kind of work d DO NOT use re	one during most of wor etired)	king 16t	School N		
	should be filed valued Mental Hygies marked other fumatic event, it		17. Father's Name (First, Middle, Last) Raymond A. McBrid 19a. Informant's Name/Relationship (T)	e			18. Mother's Nar	ne (First, Middle, Main ne Todd	den Sumame)		
ore,	es 1 and 2 of Health a fitem 27 is r other treu		Annette M. Feder1 20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ F	ine Daught	ter 108 b. Place of Disponsion commetery, createry, createry.	Willow esition (Name of matory or other	Avenue; To	Date 200		28	
Baltimore,	permit. Pag Department Important: I any injury o		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens		- 22 F	Name and A	Park 2/6/ ddress of Facility St Home of Ca nondson Ave	erling Asl tonsville	lkridge, M nton Schwa , Inc. nsville, M	h Witzke	
//	cate be executed Wedical Examiner The burial-transit	Physician/Medical Examiner	if any, leading to immediate Cause (Disease or injury	ne cause on each line.	sequence of):		+ Fa	4		Approximate Interval Between Onset and Death	
	that the death certificated by the attending phase by the attending phase es to		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time 9 □ Unknown	etal death 3	Ectopic pregn Other (specify			23d. Date of deliv Month	ery Day Year	
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	ing After uner	Certification; To Be	examiner? 1 Yes 2 No 1 27. Manner Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea.		28c.	Other: 4 Nursing H Injury at Work? 1 Yes 2 No	ome 5 Residence 28d. Describe how in		(y)	
DIVI	- 9		4 Homicide determined 29a. Certifier 1 Certifying Phy	28e. Place of Injury - A building, etc. (Sp	knowledge, deatl	occurred at th	ne time, date and place	City or Town, S.	e(s) and manner as s	stated.	
1	To the Hospital or within 24 hours at To the Funeral D completely filled in	Medical	(Check only 2 Medical Exami	Bewle.	nination and/or in	vestigation, in r	ense number	rred at the time, date	Date signed (Month,	O the cause(s) Day, Year)	
15	Sta Registr		30. Name and address of person who con Dene en Bowling 31. Date filed (Month, Day, Year) FEB 0 5 2009	711 3. Registrar's Si	Item 23a) (Type, Maide ignature	Print)	vice La	ne, Cuto	nsville,	21228 Mb	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland Appartment of Mendal Hygiene 2009 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 21, 2009 2:20 PM M January Ludwig G. Massar /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Wicomico 1106 Grant Avenue Salisbury 8. Date of Birth (Month, Day Ye June 28, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 1935 Months Days Hours Maryland 1 X M 2 □ F 73 135-28-9840 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits items 23a or 28a-f show 1 ☐ Yes 2√ No Director MD Wicomico Salisbury 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21804 USA 1106 Grant Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 153-56 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married traumatic event, the Medical Examination altimore, Maryland 21215-0036 1 ☐Yes 2X No Specify: \$ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) machinist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis Massar Mary Lillian Dwyer ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau 1106 Grant Avenue Salisbury, MD 21804 Barbara Massar/spouse 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Funéral Sur State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD Approximate Interval Between Onset and Death 23a. Part 1 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a no **Physician** Canc /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown signed by the detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, þ cate has been signal page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No 24 hours after death.
Funeral Director: After this certificate I Vital completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To ot 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 6 ☐Could not be 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the F 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 09

State Registrar 31. Date filed (Month, Day, Year) - - -FEB 0 5 2009



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Christjon Huddleston, MD, 106 Milford St., Suite 103, Salisbury, MD

		-	State O' For State Registrar	f Maryland / Depa <i>Cei</i>	artment of Health ar ctificate of Death	nd Mental Hygid Reg	ene 2009 03218
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) FRIEDA B • MILLER			2. Date of Death Month JANUARY	Day Year 28, 2009 3. Time of Death 1:30p M
T.	Examin		4a. Facility Name (If not institution, give street and nur FRANKFORT NURSING HOME	1.1	4b. City, Town, or Location of DBALTIMORE		4c. County of Death N/A
	Funeral Director		213-20-5811 1 M 2XXF	7. Age (In yrs. last birthday) 87 Yrs.	If Under 1 Year If Under 24 Months Days Hours	Min. 8. Date of Birth (Month, Day, 11–3–19	year) 9. Birthplace (State or Foreign Country) MARYLAND
	e Maryland 3a-f show tified at	Director	Usual Residence of Decedent 10a. State 10b. County MD N/A	10c. City, Town or Lo	DRE		10d. Inside City Limits 1 🛣 Yes 2 🗆 No
	ath with th 23a or 28 ust be no	ral Dire	10e. Street and Number 2301 PENTLAND DR.		10f. Zip Code 21234		g. Citizen of What Country? USA
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at ance.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Was Dece Armed Fo 1 □ Yes, Giver Year or D	rces? 2 XNo /e	Was Decedent of Hispanic Origin if Yes, specify Cuban, Mexican, I	1? (Specify Yes or No- Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: BLACK
21215-0036	within 72 ho iene. than "natul the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) -12- College (1-4-4-4-4-4-4-4-4-4-4-4-4-4-4-4-4-4-4-4	-4or 5+) (Give life. i	dent's Usual Occupation kind of work done during most o DO NOT use retired)	f working	6b. Kind of Business/Industry TEMPLE FINANCIAL
and 2	d be filed antal Hygi ed other event, t	Be	17. Father's Name (First, Middle, Last) JAMES MATTHEWS	2100	18. Mother's	Name (First, Middle, M.	
Maryland	nd 2 shoule Ith and Me 27 is mark traumation	ဥ	19a. Informant's Name/Relationship (Type. Print) MARK ROWE (NEPHEW)		ng Address (Street and Number of PENTLAND DR.	or Rural Route Number,	
altimore,	Pages 1 ar nent of Hea ant: If item 3 ury or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation /5 ☐ Othe (Specify)	State 20b. Place of Dispo cemetery, crei	matory or other place)		Oc. Location - City or Town, State ALTIMORE, MARYLAND
Baltii	permit. P Departm Importar any Inju		21. Signature of Juneral Sorvice Ligense FONATH	AN/D. HIBNER	2. Name and Address of Facility	REDD FUNERA	
	Physician		23a. Part. E ter the disease, or complications that on short is the failure. List only one cause on elimmediate y ause (Final disease a condition resulting in death)	Demo	er the mode of dying, such as ca	ardiac or respiratory arres	st, Approximate Interval Between Onset and Death
	/Medical Examiner	er	Due to	(or as a consequence of): (or as a consequence of):	et .		
,820,	icate be executed physician and s the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to Customer Cause (Disease or injury that initiated events resulting in death) Last	(or as a consequence of):			
Θ	The law requires that the death certifica te has been signed by the attending phoage 2 should be detached for use as the	Physician/Med	in the past 12 months?	nant at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
rds, P.	quires that t n signed by uld be detac	<u>م</u>	Part II. Other significant conditions contributing to d	eath but not resulting in the u	nderlying cause given in Part I.		acco use contribute to the cause of death? s 2 □ No 3 □ Probably 4 □₩πκτοννη
Division or Vital Records, P.O. Box		Completed				24a. Was an autopsy perform	prior to completion of cause of
r Vita	vysician: Th vis certificate director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Inpatient 2 ☐ ER/Outpatie	Other	of Death (Check only one sing Home 5 Resider	nce 6 Other (Specify)
o uo	Attending Physician: or death. ector: After this certification by the funeral director,	tion:	27. Manny of Death 1 Natural 5 Pending 2 Accident investigation	of Injury th, Day Year) 28b. Time of Injury	of 28c. Injury at Work? M 1 Tyes 2 No	28d. Describe how	w injury occurred
Divis	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the i	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place build	of injury - At home, farm, sting, etc. (Specify)	reet, factory, office	28f. Location (Str. City or Town,	eet and Number or Rural Route Number, State)
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in I	Medical (one) and man	asis of examination and/or in	nvestigation, in my opinion, death	occurred at the time, da	ate and place, and due to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier		29c. License number	7 9	d. Date signed (Month, Day, Year)
•	1		30. Name and address of person who completed cause	se of death (Item 23a) (Type,	Print)	de land	· MD 21234.
	Sta Registi		31. Date filed (Month, Day, Year) 5 2009 32. F	Registrar's Signature	29c. License number D5772 Print) WD0	10000	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Walter, 9:40 PM ald 200 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number 4c. County of Death Baltimore VA Medical Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 1**∑**M 2□ F Months Days Hours Min. 213-40-1007 66 Dec 19, 1942 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits MD Baltimore 1 ☐ Yes 2√ No Sparks 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 10 Fila Way 21152 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 160-63 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 salesperson 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Walter George Praydis Helen Delores Lasczak 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore VA Med Center 10 N. Green Street Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Si natur Funeral Service Licensee Renal S Wart State Anatomy Board 655 W. Baltimore Street Mirector 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Colitis disease or condition resulting in death) Due to (or as a consequence of): ficile Infection lostridium Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sclerosis 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □ Yes 2 12 No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1∐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred

The law requires that the death certificate be executed P.O. Box 68760, of Vital Records, To the Hospital or Attending Physician: Division death.

Physician

/Medical

Examiner

Funeral

Director

show

Director

Funeral

Completed

Be

Examine

Physician/Medical

Completed by

Certification: To

Medical

7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Modical Examiner must be notified at

Baltimore, Maryland 21215-0036

12 should be filed with and Mental Hygier 7 is marked other the

if of Health a

permit. Pages 1
Department of H
Important: If Iter
any Injury or ott

Physician

/ /Medical

Examiner

burial-transit

attending physician for use as the buria

signed by the a d be detached f

cate has page 2 s

this certificate

After thi funeral

Director: A

pletely filled in by

within 24 hours a

5 Pending investigation

2 Accident 3 ☐ Suicide 4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

29a. Certifier

6 ☐ Could not be determined

FFB 0 5 2009

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

11-10292

and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10 N. Greene St. Baltimore MD. MD 32. Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

			State of Maryland / Depa		Mental Hygier	ne
				tificate of Death	Reg. N	2009 03220
	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 2.18A M
	/Medic		VIRGINIA MAY PALMER 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deatl		tc. County of Death
_	Examin	er	2	enree Chen P		ANNE ARUNDEL
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.		
	Director		220-18-8927 ¹□м 2 ™ F 82 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 06/14/1	926 Maryland
	pu. *		Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Loc	eation		10d. Inside City Limits
	laryla sho	ō				1 ☐ Yes 2 🗹 No
	28a-1	Director	MD Anne Arundel Pasa	dena 10f. Zip Code	10g. (Citizen of What Country?
	with with		230 Glen Road	21122		U.S.A.
	ier death with the Marylan items 23a or 28a-f show item: ust be millind at	Funeral		Vas Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - American Indian,
9	72 hours after death with the Maryland "natural", or items 23a or 28a-f show idical Evantinary ust be notified at		1 Never Married 2 Married 1 Yes 2 No	Yes, specify Cuban, Mexican, Puert Yes 2 No Specify:	o Rican, etc.)	Black, White, etc.
8	ural",	d by	3 ☑ Widowed 4 ☐ Divorced Year or Dates:		1 .01	Specify: White
7	hin 72 ho e. an "natur Medical	Completed	(Specify only highest grade completed) (Give I	ent's Usual Occupation kind of work done during most of wor NOT use retired)	king 166.	Kind of Business/Industry
77	ien th	mo	Elementary/Secondary (0-12) College (1-4or 5+)	Care Provider	St	ate of Maryland
פ	be filed y tal Hygi d other event,	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Nan	ne (First, Middle, Maide	
Maryland 21215-0036	ould be Mental marked o	70	Henry Dodge		arie Spic	
lar	and s m					y or Town, State, Zip Code) 21122
e)	1 and 2 Health tem 27 i			Corkberry Lane		, Pasadena, MD Location - City or Town, State
altimore,	permit. Pages Department of I Important: If ite any injury or of		1 ■Burial 2 □ Cremation 3 □ Removal from State			•
臣	artme artme ortant injury	1		ren Mem Pk 02/0		en Burnie, MD Cuneral Home, PA
Ba	permi Depa Impo any is			9 Riviera Dri		
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.			Approximate Interval Between
=	Physician	ĺ	Immediate Cause (Final disease or condition	2		Onset and Death
and a	/Medical Examiner		resulting in death) Due to (or as a consequence of):			
	Examiner	<u>.</u>	Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence of):			
T	nsit	Examiner	Cause (Disease or injury			
ŕ	execu in and ial-tra	Exa	that initiated events resulting in death) Last			
8760	ficate be executed physician and s the burial-transit	dical	d			
	ertifica ing ph e as th	Med	IF FEMALE:			
Box	death certific e attending p id for use as	lan/	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 \(\subseteq \text{Live birth} \) 2 \(\subseteq \text{Fetal death} \) 3 \(\subseteq \text{Constant Pregnancy} \)	Ectopic pregnancy		23d. Date of delivery Month Day Year
O.	0 0 0	Completed by Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9 ☐ Unknown	Other (specify)		
٠ <u>.</u>	requires that the seen signed by th hould be detache	y Ph	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
Division of Vital Records,		q pa			1 ☐ Yes	2 No 3 Probably 4 Unknown
ဝ၁	¥ 20 ×	plet			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
<u> </u>	The ate h page	Com			performed?	death?
Vita	Physician: this certific	Be	25. Was case referred to medical examiner?		ath (Check only one)	
ot	Phys r this ral dir	٦.	1 ☐ Yes 2 ☐ No ☐ 10 ☐ Inpatient 2 ☐ ER/Outpatient 27. Manne Death 28a. Date of Injury 28b. Time of		lome 5 ☐ Residence 28d. Describe how in	
o	dlng th. Afte	tion	1 ☐ Hatural 5 ☐ Pending (Month, Day, Year) Injury 2 ☐ Accident investigation	28c. Injury at Work? M 1 □ Yes 2 □ No	200. Describe flow in	jury occurred
<u>Visi</u>	Attending or death. ector: After by the funer	ifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stre	et, factory, office	28f. Location (Street	and Number or Rural Route Number,
ă	tal or s afte al Dir ed in	Certification: To	4 ☐ Homicide building, etc. (Specify)		City or Town, Sta	ate)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier (Check only (Check only a physician) (Check only (Check only 2) Medical Examiner: On the basis of examination and/or inv	occurred at the time, date and place restigation, in my opinion, death occur	e, and due to the cause urred at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
	the lithin 2, the long the lon	Medical	one) and manner stated. 29b, Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
	To Your		250. Significant and Secretary Mrs.	1) zf(1/49		muary 31 2029
	110		30. Name and address of person who completed cause of death (Item 23a) (Type, F	Print)		3, 3, 1
	VΨ		ENABATO 301 Voipural	drive Gleu	Brunie	5 m) 30161
	Sta Registr		31. Date filed (Month, Day, Yehr) See Registrar's Signature	N. I		

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death - Month Februar Pay 2, 2 Year **Physician** 3120 Phillips /Medical 4a. Facility Name (If not institution, give street and number) 4b. Cîty, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, 7/19/19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🖺 F 86 220-05-4400 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 □Yes 2 No MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 items 23e 601 Crain Hwy South 21061 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 K∑Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 "natural", or white 1 ☐ Yes 2 🔀 No þ Specify: 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Sales Sales Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Peges 1 end 2 should be filk Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumattc event Be George Phillips Helen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 762 Spring Bloom Drive; Millersville, MD 21108 Mrs. Lisa Moore / daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/09/2009 | Glen Burnie, MD Glen Haven Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licensee Services, PA; 1 2nd Ave SW; Glen Burnie, MD21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** VVS V /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law regulres that the death certificate be executed signed by the attending physician and it be detached for use es the burial-tran Due to (or as a consequence of): Box 68760, Physiclan/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day 4 Pregnant at time of death Month Year 5 Other (specify) P.0. 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been si page 2 should b Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No certificate 1 ☐ Yes 2 DHNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 ☐ Yes 1 Inpatient ဥ 2 ER/Outpatient 3 DOA this funeral 27. Montair of Death 1 Whatural ne Hospital or Attending Pl n 24 hours after death. ie Funeral Director: After th Certification: 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After t 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident in by the 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completely filled 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Haspidal Drive edvae LUKK 31. Date filed (Month, Day, Year) 32 Registrar's Signature State FEB 0 5 2009 Barra Registrar

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		Decedent's Nam	ne (First, Middle	e, Last)							2. Date of I	Death		3. Time of Death
Physicia /Medic		LO	UIS	JOHN 1	POZ	ZUOL	I				Fehren		ay Year 2007	7 4:40 PM
Examin	er			n, give street and num		т.				ocation of Deatl	h	4	c. County of Deat	th
Funeral		5. Social Security N		G. Sex		(In yrs. las	t birthday)	If Under 1 Ye	ear	If Under 24 Hrs.	8. Date of E	Birth	N/A 9. Bir	thplace (State or Foreign
Director		215-30-		1 X M 2□ F		74	Yrs.	Months Da	ays	Hours Min.	FEB.	23,	1934 M	ARYLAND
ow other		Usual Residence of 10a. State	10b. County		Т	10c. City, 7	Town or Lo	cation						10d. Inside City Limits
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hours after death with the Maryland tural", or Items 23a or 28a-f show at Examiner must be notified at	Director	10e. Street and Nu			Î			10f. Zip Co				10g. C	Citizen of What Co	ountry?
eath v	eral		PELHA	AVENUE	dent S	wor in 11 S	12	Was Decedent		213	nacify Vac or I	No.	U.S.A	
ifter de	Funeral	11. Marital Status 1 ☐ Never Marr	ried 20M Marr	ied Armed For	ces? 2 □ No					spanic Origin? (S n, Mexican, Puert	to Rican, etc.)	40-	Black, White	e, etc.
ours a	d by	3 Widowed	4 Divorced	If Yes, Giv Year or Da	e ite ¶ : 9	52-6	2	1⊡Yes 2 X	Χdο	Specify:			Specify: WH	ITE
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withly jiene.	Completed	Elementary/Seco		College (1-	4or 5+	+)		BORER	eurea)			PF	RINTING	co.
e filed al Hyg I othe vent,	Be C	17. Father's Name	(First, Middle,	Last)						18. Mother's Nar	me (First, Midd	lle, Maide	en Surname)	
ould b Ment marked natic e	2	DOMINI		DZZUOLI						MARI		OZZI		
d 2 sh th and th sn traum		19a. Informant's N LARISA											or Town, State,	
s 1 an if Heal item 2 other		20a. Method of Dis		DUT\ MILI				osition (Name of matory or other		AVENUE	Date		Location - City or	21213 Town, State
Pages nent o int: if		1 X Buriai 2 4 Donation		3 ☐ Removal from S pecify)	State						2/6/09	9 BA	LTIMOR	E, MARYLAND
permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if the 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at once.		21. Signature of Ft	uporal service	Licensee	/		12/	2. Name and A	ddress	of Facility	TNC.	FUNE	RAL HO	м F .
<u> </u>		One Daniel Fater			20								'IMORE,	
		shock, or hea	art failure. List	complications that ca only one cause on ea	ach line	e.	4.0				c or respiratory	arrest,		Approximate interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	on	a. Due to (tetic conseque		nocara	ino	ma				10 Pays
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bet tist	Examiner	Sequentially list co if any, leading to in cause. Enter Under Cause (Disease or	nmediate erlying	Due to (or as a	conseque	nce of):							
e executed ian and urial-transit	Exar	that initiated events resulting in death)	S	c Due to (or as a	conseque	nce of):							
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Attending Physician: The law requires that the death certificate be octor: After this certificate has been signed by the attending physicial by the funeral director, page 2 should be detached for use as the bur	by P	Part II. Other signi	ificant condition	ons contributing to de	ath bu	t not resulti	ng in the u	inderlying cause	e give	n in Part I.				o the cause of death?
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sician: The certificate rector, pag	a	25. Was case refer	rred to medical							26. Place of Dea			No 1 □Ye	s 2 No
hysic his ce	To B	examiner? 1 ☐ Yes 2 🚺	No	Hospital: 1 👿	npatier	nt 2 🗆 Ef	R/Outpatie	nt 3 DOA	Othe	r: 4 🗆 Nursing H	lome 5 □ Re	esidence	6 □Other (Spe	ecify)
ding P	ion:	27. Manner of Dear	5 Pendin	9	of injur h, Day	y (Year) 2	8b. Time o injury		Injury Work	?	28d. Describ	e how in	jury occurred	
Attend death octor:	ficat	2 Accident 3 Suicide	investi 6	not be 28e. Place	of Inju	ry - At hom	e, farm, st	reet, factory, off		es 2□No	28f. Location	(Street	and Number or R	ural Route Number,
tal or safter	Certification:	4 Homicide		buildir	ng, etc.	. (Specify)					City or	Town, Sta	ite)	
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier (Check only one)	1 Certifyir 2 Medical	ng Physician: To the Examiner: On the ba and mann	asis of	examinatio	edge, dea on and/or in	th occurred at to	the tim	e, date and plac pinion, death occ	e, and due to t urred at the tim	he cause ne, date a	e(s) and manner a and place, and du	s stated. e to the cause(s)
To the within To the compl	Me	29b. Signature and	title of certifie					29c. Li	icense	number		29d. [Date signed (Mon	th, Day, Year)
7		1 2	Rist	Share	1	2.0	(Ji	00	61/80		Fel	bruary:	2,2009
341		30. Name and add	ress of person	who completed cause	e of de	ath (Item 2	(Type,		cite	2 Parkus	y R.	16mm	re Man	2,2009 cland 21218
Sta		31. Date filed (Mor	_	38 P	egistra	ır's Signatuı		V-1410C0		10-1100	1	- 8 B - 10 00	1147	- C-11 14 10410
Registr	ar	FE	3 0 5 20	19 Brown		1.	back	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 009 03223 1 - For State Registrar Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Youvell reorge tebruar 01 1150 AM 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Hospital Kundalistown Baltimore WD Northwest 8. Date of Birth (Month, Day, Year) Aug. 21, 1917 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 91 10M 20F Months Days Hours South Carolina 247-109351 Yrs. Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
ant: if Item 27 ie marked other than "naturel", or items 23a or 28e-f ehow ury or other treumatic event, if a Medical Examinat must be notified at 1 ☐ Yes 2 🕅 No Director Maryland Carrol1 Sykesville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21784 USA 7200 3rd Ave., Apt. A 304 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 11. Marital Status 1 ▼Yes 2 No If Yes, Give V Year or Dates: 1 Never Married 2 Married Specify: White WW II 1 ☐ Yes 2 ☑ No Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self Employed 12 Carpenter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Powe11 Brooksv Barrett Barrett Bennie Rufus 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7200 3rd Ave., Apt. A 304, Sykesville, MD 21784 Ruth E. Powell (Wife) 20b. Place of Disposition (Name of Bate 1976) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page. Depertment o Important: If any Injury or once. 2/3/09 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 Part 1 and the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) dilated Car hi um o 19thy **Physician** /Medical Due to (or as a consequence of) Examiner SEUTERE ciortic Squaritally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Fibrildation physicien and the burial-transit atrial The law requires that the death certificate be executed (hronic Due to (or as a consequence of) Physician/Medical d as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 ☐ Fetal death 3 ☐Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown ò Month Day Year 4☐Pregnant at time of death 5 Other (specify) the be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was an autopsy performed?
Yes 2 No hes certificete 1 Tes Physicien: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗶 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After or Attending 1 Natural 5 Pending Injury death. 1 □Yes 2 □No 2 Accident investigation after death the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide within 24 hours a To the Funeral Hospital Centifying Physician: To the best of my knowledge, death accurred at the time, date and place, and due to the cause(s) and manner as stated Medicai 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 2/119 1200200 2A M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 50, te 204 13715 . O. H 16 15 libraty 12 Eldersburg 32 Registrar's Signature 31. Date filed (Month, Day, Year) ----State

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

ORIGINAL

1 - For State Registrar

Physician

1. Decedent's Name (First, Middle, Last)

01:15 AM FEBRUARY VIVIAN G RASKIN 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOSPITAL BATIMORE N/A OF BALTIMORE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 11/24/1924 **Funeral** 1 M 2 X F Months Days Hours Min. 397-20-4783 84 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Funeral Director MD BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23 CAVESWOOD LANE 21117 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status 14. Race - American Indian. 1 □Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 No WHITE Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) VOLUNTEER COORDINATOR **HEALTHCARE** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be finent of Health and Mental I int: If item 27 Is marked o GINSBERG ABRAHAM MOLLY 2 SCHER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health Important: If item 27 any injury or other tra once. LISABETH RASKIN / DAUGHTER 675 SHARON PARK DR., #303, MENLO PARK, CA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORÉ HEBREW 02/04/2009 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Neu 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner EFF VSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner law requires that the death certificate be executed burial-tran Due to (or as a consequence of) attending physician for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death in the past 12 months? 3 Ectopic pregnancy Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ FIBRILLATION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed KIDNEY DISEASE. CHRONIC 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed certificate 1 □Yes >ENo 1 ☐ Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 ☐ Accident 5 Pending I hours after death uneral Director: / investigation 1 ☐ Yes 2 ☐ No the 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D0061959 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IN BELVEDERE AVE, SINN MOSPITAL OF BANTIMORE, BANT IMORE, MA AMAN SIBAL 2401 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2. Date of Death

03224

3. Time of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Rusch 18 07 PM Frelyn Madeline February 03 2004 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Baltmore VA Medical Cently If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) July 22,1923 5. Social Security Number 7. Age (In yrs. last birthday) Days Months Maryland Hours 1 ☐ M 2 ☐ 🗱 215-16-1240 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐Yes 2 XNo Baltimore Dundalk Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21222 USA 16 Vista Mobile Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Mayes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 X Married 1 □Yes 2 XNo Specify. Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Auto Painters Secretary 9 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anna Skwirut Nicholas Skwirut 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 21222 16 Vista Mobile Drive, Dundalk, Maryland Milton Resch Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) February
Crownsville VA Cemetery 9, 2009 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Connelly Funeral Home of Dundalk, P.A. ntho 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) 1 week dostridium difficult Sequentially list conditions, if any, leading to firm delecause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Day Month Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Funeral

Director

28a-f show

Director

Funeral

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Completed

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiling 1: ust the natural ance.

altimore, Maryland 21215-0036

Examiner bunal-tran physician s the burial Physician/Medical attending p certificate has been signed by the rector, page 2 should be detached Be Completed by funeral director, Certification: To this after death.

I Director: Af
d in by the fur To the Hospital or within 24 hours aft To the Funeral Dis completely filled in

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

IF FEMALE 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 No 9 Unknown Hypertonsion Corondus

25. Was case referred to medic examiner? 1 Yes 2 No

27. Manner of Dath 1 Natural 2 Accident

3 Suicide 4 Homicide

24a. Was an autopsy performed?

21201

24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 ☐Yes

al		26. Place of Dear	th (Check only one)
	Hospital: 🎢 Inpatient 2 🗌 ER/Outpatient 3 🗎 🛭	OOA Other: 4 Nursing He	ome 5 ☐ Residence 6 ☐ Other (Specify)
ling stigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred
d not be rmined	28e. Place of Injury - At home, farm, street, facto building, etc. (Specify)	ory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)

I	29a. Certifier
I	(Check only
1	one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier MI

05

5 Pen

6 □ Coul

on Groworke

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barnadzik (Slation MD 10 N greene St

discase

31. Date filed (Month, Day, Year)

32 Registrar's Signature

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10e&196 State of Maryland 6889 3/05/09 The alth and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 11:08 PM^M 18m 2009 Phyllis Strader January /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Gilchrist Hospice Towson 8. Date of Birth (Month, Day, Yea July 3, 19 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 √2 F 7.5 Yrs. England Director 578-56-1410 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Everninar must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 ☑ No MD Director Howard Columbia 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6319 Young Buck Circle 21045 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 😿 No Specify: Specify: white Completed by 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 administrator education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Herbert Sansom Joyce Sansom ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6319 Young Buck Road Columbia, MD 21045 19a. Informant's Name/Relationship (Type. Print) Jocelyn Ambrose/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signatur Funeral Struct Licensee 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia e Cause (Final months cell MON SMALL **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading Leading Leading Cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): inding physician are Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant atten for us 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year signed by the a P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 res 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 □ Yes 2 LXNo After this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) WSMW 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State

Registrar

6701N. Charles ST Tonson

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W)

32. Registrar's Signature

CHARLES

FEB 0 5 2009

31. Date filed (Month, Day, Year)

Amend 19a, per FH g888 2/10/09 TT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) WILLIAM STENEMAN 4b. City, Town, or Location of Death BACTVERE 4c. County of Death 4a. Facility Name (If not institution, give street and number) PARTIMIRE UNIVERSITY OF MAYEMO. S.T.C f Under 1 Year | If Under 24 Hrs. 8. Date of Birth May 16, 9. Birthplace (State or Foreign ¹931 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State X Yes 2 □ No Arbutus Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 21227 912 Circle Dr. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married White 1 □Yes 2 No Specify: 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) State of Maryland Accountant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Louise Fisher Joseph Lewis Steneman 19a. Informant's Name/Relationship (Type. Print) Son Joseph R. Steneman, daughter 19b Mailing Address (Street and Number or Rural Route Number. City or Town, State, Zip Code)
2110 Devere Lane Baltimore, MD. 21228 20a. Method of Disposition
1 ☑ Burial 2 ☑ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Date Lakeview Memorial Park 02-02-09 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Anibrose Funeral Home, Inc. 21227 1328 Sulphur Spring Rd. Arbutus, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) much Due to (or as a consequence of) TRAUMATIC BRAIN INJUR DAYS if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CENTIFICATION APPROVED BY MEDICAL EXAM VEHICLE COLLISION! MOTER Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 □Yes 2 □ No 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. VERTEGRAL ACTORY INTIMIES 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform FRACTURE 1 ☐Yes 2 XNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1**X**Yes 2 □ No 28b. Time of Injury 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐Yes 2 No 2A Accident 126/09 its 2 hours 3 Suicide 6 □Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide innerlogel-695 | Weedway | Halethorpe, may lend 2022 7

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number

Hospital or Attending Physiclan: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1211

State

Physician

/Medical

Examiner

Funeral

Director

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Director

2

Completed

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Physician/Medical Examiner

Be Completed by

Certification: To

Medical

th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner mast be notified at

permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important, if item 27 is marked other there any injury or other trainment.

Physician

/Medical

Examiner

attending physician and for use as the burial-tran

cate has been signed by the page 2 should be detached

certificate

After

funeral director.

PAPANGELOY

00062826

n who completed cause of death (Item 23a) (Type, Print)

GREENE ST.

Registrar

1 - For State Registrar

Physici	ian	Decedent's Name (First)	Middle, Li								2. Date of De Month	Da		Year	3. Time of	
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Funeral		5. Social Security Number		Sex		rs. last birthda	(y) If Unde	r 1 Year	If Under		8. Date of Bir				place (State of	r Foreig
Director		218-09-3462		1□M 2\(\bar{\mathbb{L}}\)F	0 , ,	89 Yrs.		Days	Hours	Min.	8. Date of Bir (Month, Da Feb. I	, Yaz	19	Cour	ntry) MD	
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fter d riten	Fun	11. Marital Status 1 ☐ Never Married 2	Married	Armed Fo 1 ☐ Yes	rces? 2 XNo						ecify Yes or No Rican, etc.)		Blac	ck, White,		
should be filed within 72 hours after death with the Maryland and Mental Hygiene. s marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examinar must be notified at	þ	3 Widowed 4 □ Di	orced/	If Yes, Gi Year or D	ve ates:		1 ☐ Yes	2 (2) No	Specify:	•			Specify	y: Wh:	ite	
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Page: nent o nt: If ry or		1. Burial 2 □ Cren 4 □ Donation 5 □ C			State 1	arylan				Feb. 200		Cro	wnsv	ille	. MD	
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Physician		Immediate Cause (Final disease or condition		PI	IEU	MOI	VIT	+							2 nsanang u	100
/Medical Examiner		resulting in death)		Due to	(or as a cons	sequence of):	10 0	0.0	N1 1	100	Cill A A		100	100	2011	C16
Examiner	<u>_</u>	Sequentially list conditions					100	MR	Nola	147	CULAR	7	(712)	177	2071	EAK
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death certificate be executed e attending physician and d for use as the burial-transit	cian/Medical															
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To the Hospital or Attending Physician: The law requires that the dowithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached				hysician: To the												
he Ho in 24 he Fu	Medical	one)	edical Ex	aminer: On the t and man	ner stated.	ination and/o	rinvestigatio	on, in my o	эріпіоп, ае	am occu	rred at the time	, date at	id place,	and due t	o trie cause(s	')
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£		31. Date filed (Month, Day	Yearl	32 F	Registrar's Sig	anature	B	AU	TIM	OR	= M	THE	LA	NI	120	25
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009

03228

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

FEB 0 5 2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Dav **Physician** 11'30 PM FEBRUARY Elsie C. Shewell 01 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner BALTIMORE AGNES HOSPITAL n/a If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 □ M 2 1 F Director 92 215-09-0135 1/13/17 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Poolica Examinat must be notified at 1 Yes 2 No Director MD <u>Baltimore</u> n/a 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 2306 Sidney Avenue 21230 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 If Yes, Give 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Specify þ 3. Widowed 4 ☐ Divorced Year or Dates: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry oe filed win. ⁴al Hygiene. ⁴ar than "r Elementary/Secondary (0-12) College (1-4or 5+) 9 <u> Glass Packer</u> <u>Glass</u> Department of Health and Mental Hygic Important: If item 27 is marked other I any injury or other traumatic event, in 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Henry Toomey Jane Estelle Wood 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Janie L. Marazas 116 S. Camp Meade Rd. Linthicum Heights, Md. 21090 more, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 2/5/09 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Yet only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SEPSIS 3 DAYS MRSA disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** PNEUMONIA MRSA IWEEK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.0. the 9 I Inknown signed it Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ SACRAL DECUBITUS 1 Yes 2 No 3 Probably 4 Unknown Completed DIABETES 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an icate has t page 2 s his certificate h I director, page Vital 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ✓Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No ၉ this ivision of After thi funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: or Attending 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) FEBRUARY MEDICAL DOCTOR 2009 P20805

Registrar DHMH 17 Rev 1/2001

State

BALTIMORE

MD

21229

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900

NTIM

FEB 0 5 2009

KW AME 31. Date filed (Month, Day, Year) CATONS

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 11:18 January 2009 ALEXANDER TRENT FRANK /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10 Sinai Hospital Battimore Baltimore City If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1**%** M 2□ F 41 Director NORTH CAROLINA 219-78-4332 OCT. 2 1967 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Pedical Examiner must be notified at once. 1 ☐Yes 2 ☐ No Director MARYLAND BALTIMORE N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1213 MOSHER STREET 21217 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐Wo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1∐Yes 2**X**∑No ð Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SELF-EMPLOYED LANDSCAPER 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ျှ EDDIE FRANK TRENT HANNAH LEE TUCKER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hannah L. Trent/Mother 1213 Mosher Street., Baltimore, Maryland 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) METRO CREMATION 102-06-09 BALTIMORE, MARYLAND 21. Signature of Funeral Service C 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. Mally 1206 W NORTH AVENUE, BALTIMORE, MD., 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 3 days Physician Septic Shock disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Resistent Staphylococcus 3 days methicillin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the attending physician and hed for use as the burial-transi Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 2 No 3 Probably 4 Unknown 1 Tes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes Z No certificate has autopsy performed? 1 Yes 2 No page 2 funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred al or Attending P s after death. I Director: After I 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital
within 24 hours a
To the Funeral I
completely filled 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29, 2009 Res-000 January MD 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Singi Sorah. W Wybs year) 0520(Hospital 31. Date filed (Month, Day, 32. Registrar's Signature State EB Registrar

			1 - For State Registrar	State of Maryland /		rtment of H <i>tificate of L</i>		Mental Hygi Rej	ene g. No 2 0 0 9	03233
	Physici	ian	1. Decedent's Name (First, Middle, Last)	4 4				Date of Death Month		3. Time of Death
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	Examir	ner	Seasons Hospice	out und manibuly			llstown		Baltin	
	Funeral		5. Social Security Number 6. Sex 1四	7. Age (In yrs. last I	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, March 2	Year) 9. Bi	rthplace (State or Foreign ountry)
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	arylan show	_	10a. State 10b. County	10c. City, To	wn or Loc	ation				10d. Inside City Limits
	the Ma 28a-f	Director	Maryland Baltimor	e Bai	1timo	re 10f. Zip Code		10	g. Citizen of What C	1 ☐ Yes 2X No
	h with		7210 Kennebunk Roa	d		21244			USA	outility:
	tems (Funeral	The market of the control	2. Was Decedent Ever in U.S. Armed Forces?	13. W	las Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
136	J within 72 hours after death with the Maryland glene. r than "natural", or items 23a or 28a-f show the Medical Exactionation rotified at	by	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	1 MXYes 2 ⊡ No If Yes, Give Year or Dates: WWII		□Yes 2∭XNo	Specify:			Thite
1215-0036	72 hou natura	Completed	15. Decedent's Educa (Specify only highest grade of	tion 16	Sa. Decede	ent's Usual Occupa	ation	ina 16	6b. Kind of Business	s/Industry
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_	othe /ent,	Be	17. Father's Name (First, Middle, Last)	Z P16	ecnan	ical Des		e (First, Middle, Ma	val Engir Biden Surname)	leering
Maryland 2	12 should be filed v h and Mental Hygie 7 Is marked other i traumatic event, III	10 B	William Uhland				Emma G1:	indemann		
Mar	d 2 sho th and 7 Is m traum		19a. Informant's Name/Relationship (Type	,					City or Town, State,	
ē,	f Healitem 2		Mary Uhland 20a. Method of Disposition			Kennebun ition (Name of atory or other place			, MD 2124	
Ē	Page:		1 Burial 2 Cremation 3 Rer 4 Donation 5 Other (Specify)	novarion State		atory or other place urch Cem	i	2009	Baltimor	e, MD
saltimore,	permit. Pages 1 and 2 should be Department of Health and Menti Important: If item 27 is marked any injury or other traumatic es ance.		21. Signature of Funeral Service Licensee		22.	Name and Addres	s of Facility Ste	erling As	hton Schw	ab Witzke
_	Oi		23a. Part 1. Enter the disease, or complica	tions that caused the death. De	116	30 Edmon	<u>dson Aver</u>	nue: Cato	nsville,	MD 21228 Approximate
	Physician	0.5	Immediate Cause (Final	cause on each line.		Λ	g, such as cardiac	or respiratory arres	ι,	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequence		Hyrost				
	Examiner	<u>.</u>	Sequentially list conditions, b.	Due to (or as a consequence	rtor	y Disea	356			
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence	e oi):	•				
Ď,	e exection and unial-tr	Exa	resulting in death) Last	Due to (or as a consequence	e of):					
08/00,	ficate be executed physician and s the burial-transit	edical	d							
DOX O	n certifi anding use as		IF FEMALE: 23b. Was decedent pregnant 23c	. If yes, outcome of pregnancy					23d. Date of de	alivery
ָ מַ	ed for	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
7	n. After this certificate has been signed by the funeral director, page 2 should be detached		9 ☐ Unknown Part II. Other significant conditions contri		in the und	derlying cause give	n in Part I	23e. Did toba	cco use contribute t	o the cause of death?
ecords,	quires en sign uld be	d by	Hypertension							robably 4 [_/Unknown
ည သ	as bee 2 sho	Completed	Diaboles Mollips					24a. Was an	24b. Were a	utopsy findings available
֡֟֝֟֝֟֝֟֝֟֝֟֝֟֝֟֝֟֝֟֝֟֝֟֝֟֝֟֟֝֟֝֟֜֟֝֟֟֜֟֝	cate h page	Com	Chronic obstruct	we Pulmonary	Dis	ase		autopsy performe 1 □ Yes 2 [d? death?	completion of cause of
N	s certif) Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	spital:	D. 44	Otho		h (Check only one)	Sintson	us itospicle
5 i	ig Fny ter this neral o	n: To	27. Manner of Death	1 ☐ Inpatient 2 ☐ ER/C 28a. Date of Injury (Month, Day, Year) 28b.	Time of Injury	28c. Injury Work	at Nursing Ho	me 5 Hesideni 28d. Describe how	injury occurred	us itospice
NISIOII	tendir leath. tor: Al the fu	catic	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			M 1 □ Y	es 2 □No			
5	after of Direct of Jin by	Certification:	4 Homicide determined	28e. Place of injury - At home, f building, etc. (Specify)	farm, stree	et, factory, office		28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
	To the propriat or Attending Prhysician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical C	29a. Certifier (Check only one) 1 Certifying Physic 2 Medical Examine	ian: To the best of my knowledger: On the basis of examination a	ge, death and/or inve	occurred at the timestigation, in my op	e, date and place, inion, death occur	and due to the cau	ise(s) and manner a e and place, and du	s stated. e to the cause(s)
	vithin :	Med	29b. Signature and title of certified	and manner stated.		29c. License	number	290	l. Date signed (Mon	th, Day, Year)
	١.		Nelvah Bul	u		H49	5931	F	Gbruary	444 2009
1	2+1		30. Name and address of person who complete and Bwtm		(Type, P	int) SUI	e 203	Baltime	OVE MD	21208
Ė	Sta		31. Date filed (Month, Day, Year) FFR 0 5 2000	32. Registrar's Signature	1					-

09-00268 Kathy Valentine

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

atr	ny valentine		State of Maryland / Department of Health and Mental Hyll 1- For State Certificate of Death Registrar	gierie Reg	. No. 21	009	03231
VI o	Physicia	in/	1 Decedent's Name (First Middle Last)	2. Date of Death Month January 9, 2	Day Yea		Time of Death 2316 hrs
viet	dical Exami		Kathy Diane Valentine 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	January 9, 2	4c. County	of Death	
			Prince George's Hospital Center Cheverly		Prince C		
	Funeral Director		5. Social Security Number 578-94-1459 6. Sex 1 M 2XF 52 7. Age (In yrs. last birthday) 1 M 2XF 52 Yrs. F Under 1 Year If Under 24Hrs. Months Days Hours Min.	8. Date of Birth		9. Birthp Foreign Count	Washington, try) DC
	any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				0d. Inside City Limits
	* .	ь	Maryland Prince George's Seat Pleasant				1 X Yes 2 No
	the Maryland 3a or 28a-f sho	Director	10e. Street and Number 10f. Zip Code		. Citizen of WI	nat Country	λ5.
1	hours after death with the Maryland natural", or items 23a or 28a-f sh Examiner must be iffed at once		728 Rooker Drive 20743 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe		USA 14. Race	- America	in Indian, Black,
	leath w	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto F		White	e, etc.	
7	after c	by F	3X Widowed 4 Divorced If Yes, Give Year or Dates:	in an a	Specify: 16b. Kind of Bu		ack
	2 hours af "natural" Examin	ted	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of we during most of working life. DO NOT use retire telephone (1-4 or 5+)				usity
	036 ithin 7; ne.	ompleted	12 Cosmotologist		Entrep	rene	ur
	more, MD 21215-0036 Pages I and 2 should be filed virthin 72 tent of Health and Meintal Hygiene. nut: If item 27 is marked other than "	Ö	17. Father's Name (First, Middle, Last) 18.Mother's Name (Marcan	First, Middle, Markette J.		;)	
	2121 uld be fi Mental marked c event,	o Be	Ernest Williams Margar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ri			vn, State, 2	Žip Code)
	, MD 212 and 2 should be each and Menta em 27 is marke traumatic even	[Ernest Williams - Father 4218 28th St. #3, Mt.			20712	
	or Heal		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	İ	20c. Location		
	Baltimore, permit. Pages I an Department of Hea Important: If iten	184 12	4 Donation 5 Other Specify: Ft. Lincoln Cemetery 1/2	6/2009	Brenty		
	Baltimore, MI permit. Pages 1 and 2 s Department of Health as Important: If item 27 injury or other traum		21. Signature of Fineral Service Licensee Licensee 22. Name and Address of Facility For 3401 Bladensburg Rd				20722
	Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or failure. List only one cause on each line.	respiratory arres	st, shock, or he	art	Approximate Interval Between Onset and
1	/Medical xaminer	i	Immediate Cause (Final disease a. Hypertensive atherosclerotic cardiov	ascualr	diseas	e	Death
•			or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.				
		iner	If any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause			- 1	
,	d sit	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
	xecuted n and I - transit		d. X UNPENDED 23a,PII,2/,perME, g888 2/18/09	TT			
	lox 68760, leath certificate be exe e attending physician a for use as the burial -	Physician/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of	of delivery	
	Box 687, death certificate attending ped for use as the	ian/I	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnant 4 Pregnant at time of death 5 Other (Specify)	ncy	Month	Da	ay Year
	Box death of he atter d for us	ysic	1 Yes 2 No 9 V Unknown 4 Pregnant at time of death 5 Other (Specify) 9 Unknown				
	P.O. B res that the d signed by the be detached	by Pt		23e. Did tot			ne cause of death?
	Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	73	Diabetes mellitus	24a. Was a			opsy findings available
	COFC law rehas be	Completed		autops perform	ned?	death?	impletion of cause of
	Vital Records, sysician: The law requirents certificate has been sedirector, page 2 should	Col	25. Was case referred to medical 26.Place of Death (Check of D	1 Yes 2	No No	1 🗸 Yes	2 No
	Vital Rec hysician: The this certificate I director, page	To Be	examiner? Hospital: Other, Other,	g Home 5	Residence 6	Other:	
	n of \ding Phy. After the function		1 X Notice (Month, Day, Year)	28d. Describe h	ow injury occui	rred	
	Sior Attendar r death ector: by the	catic	2 Accident Investigation 28e Place of Injury - At home farm street, factory, office building, etc.	28f. Location (S	treet and Num	ber or Rurr	al Route Number, City
	Divi	Certification:	3 Suicide 6 Could not be determined (Specify) (Specify)	or Town, St			
	Division of Vital Records, P.O. Box 68760, vithin 24 hours after death errificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical C	29a. Certiffer 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated.	due to the cause t the time, date a	e(s) and manne and place, and	er as stated due to the	t. cause(s)
	F » F S	Me	29b. Signature and title of certifier 29c. License number		29d. Date sig		
			lalum O.C.M.E.		January 1	0, 2009	
	R		30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 212	201			
		tate	31. Date filed (Mosth, Day, Year) 32. Kegistrar's Signature				
	Regis	trar	FEB 0 5 2009 Clemen 15. 19				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) February 2 2009 **Physician** 7:30 AM TERROD WATKINS /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Greater Baltimore Medical Ctr. Towson Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Days Min. 1 □ M 2 TF Months Hours 0 FEB. 2, 2009 MARYLAND Director N/A Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, the Modeal Exactions out the notified at 1 X Yes 2 ☐ No Director MARYLAND BALTIMORE N/A 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 26 Lloyd Street 21202 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Yes} \) \(\text{XNo} \) Race - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours after Hygiene. Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XX Specify Specify: BLACK If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit, Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any Injury or other traumatic event, Its Invide once. College (1-4or 5+) Elementary/Secondary (0-12) N/A N/A 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be TERROD WATKINS TORAINE WILSON ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Maryland_21202 26 Lloyd Street, Baltimore, Toraine Wilson/Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 02-04-09 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 21. Signature of Funday Signature License 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. Rollin 1206 W NORTH AVENUE 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Extreme Prematurity **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Clusease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ctopic pregnancy
5 Other (specify) Year Month Day ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. \$ 2No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 SNo 1 ☐ Yes 2 No certificate 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Npatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 24 hours after death.

Funeral Director: After the etely filled in by the funeral 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 hor To the Fune completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of contifier

State Registrar 31. Date filed (Month; Day, Year)

FEB 05

DHMH 17 Rev 1/2001

Darks

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kimberly Bernard, MD., 67

7058709

MD., 6701 N. CHARLES STREET, BALTIMORE, MARYLAND 21204

			For State	State	of Maryl	and / Depa	artment of I			lental H	ygien Reg. No	201	9	03236
			Registrar 1. Decedent's Name (First, Middle	e, Last)						2. Date of D	eath			3. Time of Death
	Physici		TORAINE 1	WATKINS						Month Febr	uar'		Year 2009	6:30 P
-	/Medio Examir		4a. Facility Name (If not institution	n, give street and n	umber)		4b. City, Town, o	or Location	of Death			. County o		
-			Greater Balt	imore M				Tows				Ва	ltin	
ı	Funeral Director		Social Security Number N/A	6. Sex 1 □ M 2 X CXF	7. Age (In	yrs. last birthday) O Yrs.	If Under 1 Year Months Days		Min.	8. Date of B (Month, I	Day, Year,		Coun	lace (State or Foreig etry) LAND
	and		Usual Residence of Decedent 10a. State 10b. County		10c.	. City, Town or Lo	cation						1	0d. Inside City Limits
	Maryl f sho	ţō	MARYLAND N/	7\		BALT	TMODE							1⊠Yes 2□No
	r 28a	Funeral Director	10e. Street and Number	Α		DALI	10f. Zip Code				10g. C	itizen of W	hat Coun	itry?
	h with	a D	26 Lloyd Stre	eet			2120	02			U	.S.A.		
	ems deat	iner	11. Marital Status	12. Was De	cedent Ever i	n U.S. 13.	Was Decedent of If Yes, specify Cub	Hispanic C	origin? (Spe an, Puerto	ecify Yes or N Rican, etc.)	0-		- Americ	an Indian,
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, Its Medical Evar, event in the mother of the read of t	þ	1 XNever Married 2 Married 3 Widowed 4 Divorced	ried 1 ☐ Yes	2 XNo Give		1 ∐ Yes 2 🔀 No					Specify:	BLA	
5-0	72 hc	Completed	15. Deceden (Specify only highe:	it's Education st grade completed	1)	16a. Dece	dent's Usual Occu kind of work done DO NOT use retire	pation during mo	st of worki	ing	16b. k	Kind of Bus	siness/Ind	dustry
121	/ithin ne. han	I du	Elementary/Secondary (0-12)	College	(1-4or 5+)			ed)			NT.	/3		
	iled v Hygie ther t	ပိ	17. Father's Name (First, Middle,	Last)		N,	A	18. Mot	her's Name	(First, Middl		/A n Surname	1)	
Maryland	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, Itam	To Be	TERROD WATKI										,	
Z.	shoul nd M marl	۲	19a. Informant's Name/Relations			19b. Mailir	ng Address (Stree			WILSO al Route Num		or Town, S	State, Zip	Code)
	1 and 2 Health a tem 27 is		Toraine Wilson	/Mother		26 L	Loyd Stre	eet.	Balti	more.	Marv	land	2120	12
ore,	of He		20a. Method of Disposition		20	b. Place of Dispo cemetery, crer				Date		ocation - 0		
Ë	Pagement ant: It ury o		1 ☐ Burial 2 X Cremation 4 ☐ Donation 5 ☐ Other (S		n State	METRO CI		i	02-04	-09	BAL	TIMOF	RE, M	MARYLAND
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		21. Signature of Fameral Service	Licenses		W. 22	2. Name end Addr LLLIAM C	ess of Faci BROW	ility N COM	MUNITY	FUN	ERAL	HOME	P.A.
	# O			Duoliu	0	12	206 M NOI	RTH A	VENUE	}				
			23a. Part 1. Enter the disease, or shock, or heart failure. List	only one cause on	each line.	leath. Do not ent	er the mode of dy	ing, such a	is cardiac (or respiratory	arrest,			Approximate Intervel Between Onset and Death
-	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)			me Pren	naturit	у					_	
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		er	Sequentially list conditions, if any, leading to immediate	b. — Due to	o (or as a con	sequence of):								
1	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events	S .										
v O	an an rial-tr	Exa	resulting in death) Last	Due to	o (or as a con	sequence of):								
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit:	dical		d		_								
9	ertifica ling pl	Med	IF FEMALE:											~
Вох	eath certific attending p	ian/	23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of pre e birth 2 1	Fetal death 3	Ectopic pregnan	су				23d. Date Mon		ery Day Year
	he de	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Uni	gnant at time known	of death 5L	Other (specify)							
P.O.	that the denetation detached		Part II. Other significant condition	ons contributing to	death but not	resulting in the u	nderlying cause gi	ven in Pari	t I.	23e. Did	tobacco	use contri	bute to th	ne cause of death?
Records,	luires that n signed I lid be det	d by								1 🗆	Yes 2	No :	3 ☐ Prob	ably 4 🗆 Unknow
Ö	tw require s been si should t	Completed								24a. Wa	s an	24b. W	ere auto	psy findings available
Re	The la te ha age 2	E O			-					per	opsy formed? 2 2 N	de	eath?	psy findings available inpletion of cause of
of Vital	ian: 'rtifica	BeC	25. Was case referred to medical	ı				26. Pla	ce of Death	1 ☐ Yes n (Check only		0 1	□Yes	ZUNO
>	nyslci nis ce direc	To B	examiner? 1 ☐ Yes 2 ☑No	Hospital:	Inpatient :	2 ER/Outpatier	nt 3 DOA Ot	hor:		me 5∐Re		6 ☐ Othe	r (Specify	y)
0	ng Pt fter th neral	L:uc	27. Manner of Death 1 Natural 5 ☐ Pendin		e of Injury onth, Day, Yea	28b. Time of Injury	28c. Inju	ıry at		28d. Describe	how inju	iry occurre	d	
Sio	eath. or: A	catic	2 ☐ Accident investig	gation			M 1	Yes 2	□No					
Division	al or Att s after de il Direct	Certification:	3 ☐ Suicide 6 ☐ Could l 4 ☐ Homicide determ	nined 28e. Plac buil	ce of Injury - A ding, etc. <i>(Sp</i>	At home, farm, str pec <i>ify)</i>	eet, factory, office				(Street a wn, Stat		r or Rura	I Route Number,
	To the Hospital or Attending Physician: The lav within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical (29a. Certifier (Check only one) Certifyir 2 Medical	ng Physician: To the Examiner: On the and ma	he best of my basis of exar anner stated.	knowledge, deat mination and/or in	h occurred at the vestigation, in my	time, date opinion, d	and place, eath occur	and due to the red at the time	e cause(e, date ar	s) and mai nd place, a	nner as s nd due to	tated. the cause(s)
	Vithii vithii To th	Me	29b. Signature and title of contifie	1//			1	se number			29d. Da	ate signed	(Month,	Day, Year)
			1 Lalle	11.11			DC	105	870	7		211.	109	7
	1		30. Name and address of person	who completed ca	use of death	(Item 23a) (Type,	Print)							
	1		Dr. Kimberly	Bernard,	MD.,	6701 N.	CHARLES	STREE	ET, B	ALTIMO	RE,M	ARYLA	ND 2	1204
	Sta Registr		31. Date filed (Month, Day, Year)	32.	Registrar's S	ignature								
DL	MH 17 Rev 1/2		FEB 0 F	2009	Crown	B. 19	arkel							
DΠ	1941 17 FIEV 1/2	001												

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2009 ARIS NHAL /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner SPRINC MONTGOMERG UBR HOSPIT If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Numberunk 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 M 2□ F UNV Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, Ite Medical Examinar munt be netified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Nes 2 No by Funeral Director ΝL NWN UNV 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number UNK NUK 11 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status UNK 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐ No Specify If Yes, Give Year or Dates: Specify NNV NIBIL 3 Widowed 4 Divorced NUN Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) UNK UNK 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be NUN NUN ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20 1500 FOREST GLEN SILUER SPRING MO HOLY CROSS HOSPITAL 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of I Important: If ite any Injury or of once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5型Other (Specify) in state 21. Signature of Fineral Service Ucensee Honald Wade State Anatomy Board 655 W. Baltimore Street Director 21201 Baltimore, MD 23a. Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of): Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of) Examiner SP Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed PNEUMONIE BRONCHO and burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death Month Day 5 ☐ Other (specify) ☐Yes 2☐No 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 2 □ No Yes 2 No 1 XYes completely filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 2 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 1 Inpatient Certification: To this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Man r of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident 24 hours after deat Funeral Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D50987 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) glen vd sihun s AHMED NAW A 1500 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year O 9 Day **Physician** Shae Williams 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Square Ose dale 1405 rantin If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 X M 2 □ F Months 05^{Min.} infant Jan 20, Maryland Director Usual Residence of Decedent 10c City Town or Location 10a State 10h Counts 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√ No Director MD Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1526 Alconbury Road 21221 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. Specify: black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) infant infant infant infant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Be 2 should be f. and Mental F. Marie Williams ဥ 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Franklin Square Hospital 9000 Franklin Square Drive Baltimore, MD item 27 i 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H important; If ite any injury or otl 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5፟ Other (Specify) in state 21. Signature of Euneral Servicensee Ryn 11. S. Wade, Director 22 Name and Address of Facility Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** rematurit disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the burial-transit and Due to (or as a consequence of) attending physician Physician/Medical 38 IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) signed by the at d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown been si should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe this certificate 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral dir 27. Manner of Death 28c. Injury at 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred (Month, Day 1 Natural 5 ☐ Pending investigation 1 🗌 Yes 2 🗌 No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

certificate be executed Box 68760. P.O. Division or Vital Records, To the Hospitai within 24 hours a To the Funeral L

21215-0036

Maryland

Baltimore,

State Registrar

Medical

29a. Certifier

29b. Signature apolitile of certifi

31. Date filed (Month, Day, Year)

Pascaline

DHMH 17 Rev 1/2001

Marcelin

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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1 Zertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Kes

29c. License number

0000

Franklin Square Drive

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician 11:35 AM Ann January 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Johns Hooking Bayview Medica 5. Social Security Number 9 6. Sex 77. A | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 04/21/1922 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 219-12-7554 1 □ M 2 3 F Maryland 86 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State 1 Yes 2 No Director N/A Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 707 S. Bethel Street 21231 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11 Marital Status 1 ☐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Specify. Specify: White ģ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Barmaid Tavern 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Katherine Bondrisk John Rizulok ဂ္ 19a. Informant's Name/Relationship (Type. Print)
Albert E. Woods, Jr. / 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 707 S. Bethel Street Baltimore, Maryland 21231 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State 01/30/2009 Holv Redeemer Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) ce of Funeral Service 22. Name and Address of Facility David J. Weber Funeral Homes PA 401 S. Chester St. Baltimore, Maryland 21231 23a. Part 1. Enter the disease shock, or heart failure. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 12 hours MegaL OKIC disease or condition resulting in death) /Medical Due to (or as a conse to nce of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 2 □ Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division of Vital Records, 4.0. Box 68760,

law requires that the death certificate be execute attending please for use as t cate has been signed by the page 2 should be detached certificate has Physician: The funeral director this After or Attending death. within 24 hours after death To the Funeral Director: filled in by the To the Hospital completely

physician and s the burial-trans

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Evarcitant is ust be notified at

Baltimore, Maryland 21215-0036

State Registrar

(Check only one)

29b. Signature and title of certifier

lonathan Dukes 31. Date filed (Month, Day, Year) Medicul

Eastern

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Begistrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

Baltimore

29d. Date signed (Month, Day, Year)

2009

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 12:300 M 4a. Facility Name (If not institution, give street and number) warren 2 09 /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore 711 Maiden Choice Lane #108 Catonsville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (S Country) March 5,1921 Maryland 5. Social Security Number 7. Age (In vrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 □ M 2 🕱 F 87 **Director** 214-12-1921 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ital Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 □Yes 2 No Funeral Director Catonsville Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21228 USA 711 Maiden Choice Lane #108 Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?
1 ∑Yes 2 ☐ No
If Yes, Give
Year or Dates: Black, White, etc. 1 ☐ Never Married 2 ☐ Married White Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify. Specify. Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Real Estate Broker 7 Is marked other traumatic event, to 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be t and 2 should be fill Health and Mental H tem 27 Is marked ott Lucy Wescott Edward L. Imbach ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 195. Mailing Address (Street and Number of Third Tourist Tourist Tourist Tano, CA 28331 Avenida La Mancha; San Juan Capistrano, CA 92675 Mark Warren Son permit. Pages 1 and Department of Health Important: If item 27 any injury or other to once. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ₺ Burial 2 □ Cremation 3 □ Removal from State Loudon Park Cemetery 2-11-2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Liden 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final End-Stuge hysician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) that the death certificate be executed burial-trar Due to (or as a consequence of) Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) P.O. 9 Unknown 9 Unknown signed | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 Yes 2 No 3 Probably 4 Unknown vascular Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hypertensio page 2 s autopsy Physician: The certificate 2 No 2 No Division of Vital 1 □ Yes 1 Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this After this funeral c 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending n 24 hours after death.

Ne Funeral Director; A
pletely filled in by the fu death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 X1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Choice Lane, Catonsville, mp 21228 711 Maide Veneen Bowlin 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Marvland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** William Anderson 18, 2009 8:41 Δ /Medical Jaunary 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Cheverly Prince George's If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1**7** M 2□ F 577-50-5305 67 Director March 21, 1941 Washington, DC Usual Residence of Decedent 10d. Inside City Limits show 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinating the notified at 1 TyYes 2 □ No Director Maryland Prince George's Capitol Heights 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 505 - Rollins Avenue 20743 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 Black. 1 ☐ Yes 2 No Specify δ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 years College (1-4or 5+) DC Fire Fighter Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Edward Anderson Martha Hewlett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria E. Anderson - Wife 505 - Rollins Avenue Capitol Heights, MD 20743 Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery Jan 24, 2009 Clinton, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral Service Live 4001 Benning Road, NE Washington, DC 20019 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Fatal Cardiac Arrhythmia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Respiratory Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-trar resulting in death) Last Due to (or as a consequence of): physician at the burial P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 □Yes 2 □No 9 Unknown signed by t 1 be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ※ Unknown Completed Diabetes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed? certificate HTN 1 ☐ Yes 2 ☐ No 1 □ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐Yes 2 📆 No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After thi funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. illed in by the f 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide after within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0065367 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Medhi Sattarian 3001 Hospital Drive Cheverly, MD 20785 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 12:39 P Ρ. 2009 Alexander 9. /Medical January 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rose Mary Place Upper Marlboro f Under 1 Year | If Under 24 Hrs. Prince George's 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2 ☐ XF 251-38-9240 82 Director <u>April 19, 1926 South Carolina</u> Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Marylanc 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at Director 1 X Yes 2 No District of Columbia Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2008 - 38th Street, SE #301 20020 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ♣No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: **Black** þ Specify. 3 ☑ Widowed 4 ☐ Divorced "natural" Completed other than "natur 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 8 years College (1-4or 5+) and Mental Hygiene Domestic Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Daniel Pogue Ellen DeVore 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Louella F. Alexander - Daughter 2008 - 38th Street, SE #301 Washington, DC 20020 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If any Injury or once. = 5 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Jan 16, 2009 Suitland, MD Lincoln Mem. Cemt. 4 ☐ Donation 5 ☐ Other (Specify) permit. 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral Service Licensee. _4001 Benning Road, NE Washington, DC 20019 23a. Part Ent. r the disease, or complications that caused the shock, or leart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Alzheimer's Disease Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) ned by the a detached for 9 Unknown 9 Unknown certificate has been signed rector, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۾ Stage 4 Sacral Pressure Ulcer 1 ☐ Yes 2 【本No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 🛣 No 1 ☐ Yes 2 No director, 25. Was case referred to medical Assisted 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No After this Certification: To To the Hospital or Attending Ph within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RIID: MD20969 January 14, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eric DeJonge, MD 110 Irving Street, NW Washington, DC 20010 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State 2009 Registrar

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** anuary 18 200 <u>Rachel</u> Azər Algəze /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Community Hospital Lanham Prince George's Doctors 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
July 17, 1919 9. Birthplace (State or Foreign 6. Sex **Funeral** Months Days Hours Min. New York, NY 1 ☐ M 2 😾 F 89 116-05-4434 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show injury or other traumatic event, the Medical Examinar must be notified at Maryland Prince George's Greenbelt X□Yes 2□No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 20770 36 Crescent Road United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 M No If Yes, Give Year or Dates: "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 □XNo White Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Victor Azər Rose Russo 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lenore R. Algaze -daughter 36 Crescent Road Greenbelt, Maryland 20770 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Mt. Lebanon Cemetery 1/21/2009 Adelphi, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bonald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland20705 21. Signature of Funeral Service Licenser 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 9 **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed anding physician and use as the burial-transit Exami Ir rilla P.O. Box 68760, Physician/Medical ension signed by the attending the detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 Tes 2 No 3 Probably 4 Unknown Completed funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2000 No certificate 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📈 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No death. investigation To the Hospital or Attend within 24 hours after death To the Funeral Director; 2 Accident completely filled in by the f 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 29c. License number 52500 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Abdulwahabe, MD. 8118 Good Luck Rd, Lasham, MD. 20706 rozia 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 1:00 WILLIAM HARRY AUSTIN, SR. JANUARY 21 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2820 HUNTING CREEK ROAD HUNTINGTOWN CALVERT Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) JAN. 5,1924 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**X** M 2□ F 85 Director 217-14-8747 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 Yes 2 No Directo **PUNTA GORDA** CHARLOTTE **FLORIDA** 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 3206 COQUINA ESPLANADE 33982 UNITED STATES Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 XYes 2 □ No 1 Never Married 2 Married If Yes, Give 42-1946 Year or Day 42-1946 1 □Yes 2 No Specify: Specify: WHITE Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) WATERMAN SEAFOOD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MELISSA HELENA STEVENS ဥ BENJAMIN FRANKLIN AUSTIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health as Important: If item 27 is any injury or other trau GAIL LEE AUSTIN/WIFE 3206 COQUINA ESPLANADE, PUNTA GORDA, FL 33982 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition JANUARY 27 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State STEVENSVILLE CEMETERY STEVENSVIILE, MD 2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 23a. Part1. Enter le disease, or complicate es that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one call are each line. 106 SHAMROCK ROAD, CHESTER, MD 21619 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or s a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Jiscase of Figury) that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: 23b. Was decedent pregnant

Physician /Medical Examiner

burial-transit

attending physician and for use as the burial-trar

signed by t 1 be detach

Jas

After this

Director:

Hospital within 24 hours a

filled in by

2

Completed

Be

Certification: To

Medical

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records. P.O. Box 68760

the Maryland

filed within 72 hours after death with

Baltimore, Maryland 21215-0036

ir than "natural", or items 23a or 28a-f show the Medical Exeminer must be notified at

and Mental Hygiene.

Pages 1 and 2 should be nent of Health and Mental

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death

3 🗆 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Day Month

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

23e. Did tobacco use contribute to the cause of death?

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

9 Hlnknown

24a. Was an autopsy performed

24b. Were autopsy findings available prior to completion of cause of death?

2 X No 1 □Yes 26. Place of Death (Check only one) DAUGHTER'S Other: 4 Nursing Home 5 Residence 6 NORESTOCK

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2√ No 27. Manner of Death

1 Natural

2 Accident

4 Homicide

31. Date filed (Month, Dath

3 Suicide

in the past 12 months?

2 No

1 TYes

5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day, Year) 28b. Time of

1 Inpatient 2 ER/Outpatient 3 DOA

Injury 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of per

inpleted cause of death/(Item 23a) (Type, Print)

Yospital Rd. Swife 30

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2009 Year 9:10 A M January 24, Leola Ack Bernadine 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Allegany Lonaconing Egle Nursing Home 7. Age (In yrs. last birthday) 92 vrs 8. Date of Birth (Month, Day, March 8 Birthplace (State or Foreign
Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 1916 Days Hours 1 □ M 2X7XE Maryland 216-07-7249 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1⊠Yes 2 No Westernport Allegany MD. 10f. Zip Code 21562 10g. Citizen of What Country? 10e. Street and Number 246 Wood St. United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2√No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: white 1 ☐ Yes 2 XNo Specify: **ॐ**Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Fiber Manufacturer College (1-4or 5+) Elementary/Secondary (0-12) Secretary 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph P. Guy Bertie M. Reeves 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 248 Wood St, Westernport, Maryland Ronald Bean/ friend 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Philos Cemetery 20a. Method of Disposition 01/26/ 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Westernport, Maryland 2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Serv Licenses 22. Name and Address of Facility Boal Funeral Home 111 Church St, Westernport, Maryland 21562 Approximate
Interval Between
Onset and Death
Julia 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Combovascalar accident Immediate Cause (Final disease or condition

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral Director

Completed by

Be

2

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Welfall Evan is a must be notified at once.

Baltimore, Maryland 21215-0036

e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Property of the attending physician and benen signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	resulting in death)	Due to (or as a conseq	uence of):				
iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b Due to (or as a conseq	uence of):				
al Exam	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a conseq	uence of):				
dici	•	d					
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of 0	al death 3 Ectopic p			23d. Date of de Month	elivery Day Year
d by Ph	Part II. Other significant conditions of Prier Corkbovus Cusonary are	contributing to death but not res	sulting in the underlying c	ause given in Part I. 5 C / Crofic	23e. Did tobacco		o the cause of death? Probably 4 Unknown
Somplete	Cosonary as	tory disease	Hyperte	ASIONY	24a. Was an autopsy performed?	death?	utopsy findings available completion of cause of s 2 \(\square\) No
Be (25. Was case referred to medical			26. Place of De	ath (Check only one)		
	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐] ER/Outpatient 3 □ DO	Other: 4 Nursing I	Home 5 🗆 Residence	6 ☐ Other (Sp.	ecify)
tion: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how in	jury occurred	
ertifica	3 Suicide 6 Could not be determined		nome, farm, street, factory	, office	28f. Location (Street City or Town, Sta	and Number or F ate)	Rural Route Number,
Medical Certification: To	29a. Certifier 1 Certifying Pi (Check only one) 2 Medical Exa	Physician: To the best of my known miner: On the basis of examinating and manner stated.	owledge, death occurred ation and/or investigation	at the time, date and place, in my opinion, death occ	ce, and due to the cause curred at the time, date a	e(s) and manner a and place, and du	as stated. ue to the cause(s)
Me	29b. Signature and title of sertifier	10		c. License number	29d. l	Date signed (Mon	th, Day, Year)
	1 / hors	1 Devline	8	D21488	Ú	Tunuwi	24,2009
1	30. Name and address of person who	completed cause of death (Ite	m 23a) (Type, Print)	. /		y. 1	1 2:0-6
ł	Thomas J. L	Jevin, 20 110	45145 MVC	nue Conac	uning,	14/7/14.	12 61334

State Registrar

within 24 hor To the Fune completely f

, 20 Douglas 32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 18 2009 9:20 A JANUARY NATHANIEL BELL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEROGE'S LAUREL LAUREL REGIONAL HOSPITAL 8. Date of Birth (Month, Day, FEB 20 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days MARYLAND Hours Min. 1 ₩ 2 □ F 1937 217-32-1693 71 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examiner must be notified at 1√Yes 2 No Director PRINCE GEORGE'S LANHAM MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 5504 BALTIMORE AVENUE 20706 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married BLACK Baltimore, Maryland 21215-0036 1 □Yes 2 ី No Specify: þ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygienn Important: If item 27 is marked other the any injury or other traumatic event, Item 2008. LABORER 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be AMY JACKSON LAWRENCE BELL SR. ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) 6615 IAN STREET NEW CARROLLTON, MARYLAND 20784 GAIL ROYSTER/DAUGHTER 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RESURRECTION CEMETERY 1/26/2009 CLINTON, MARYLAND J. B. JENKINS FUNERAL HOME 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sunsequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No ed by the detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown ASPIRATION PNEUMONIA Completed 24b. Were autopsy findings available prior to completion of cause of death? SEPSIS 24a. Was an autopsy performed? 2 🔯 No 1 ☐ Yes 1 □ Yes 2 😾 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Nation 2 Self-Outpatient 3 DOA Certification: To this filled in by the funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Injury 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical within 24 ho

To the Function 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 19, 2009 **JANUARY** D24721 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14333 LAUREL BOWIE ROAD # 208 LAUREL, MARYLAND 20708 SYED SADIQ M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 2 3 2009

DHMH 17 Rev 1/2001

Registrar

			For State Registrar			rtificate of l		R	leg. No.	0000	03247
г	Physicia	an	1. Decedent's Name (First, Middle, Last)		7.4.011			2. Date of Dea Month	Day	y Year 6 2009	3. Time of Death 2:25P M
- 18	/Medic	al	MARGARET 4a. Facility Name (If not institution, give st		EACH	4h City Town or	Location of Death	JANUARY		County of Death	2:23F
	Examin	er	PRINCE GEORGE'S H			CHEVERL				RINCE GEO	RGE 'S
	Funeral		Social Security Number 6. Sex	7. Age (In yr	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year)	9. Birthp	lace (State or Foreign
	Director		578-40-1032	M 250 F 78	Yrs.	World Days	Flours IVIII.	DEC. 2	1930	0 WASHI	NGTON, DC
	and w		Usual Residence of Decedent 10a, State 10b, County	10c. C	City, Town or Lo	cation				1	0d. Inside City Limits
	/anyla	٥		ODCE!S RI	LADENSB	IIRC					1 XYes 2 □ No
	the N	Director	MD PRINCE GE 10e. Street and Number	ORGE 3 DI	TADEMOD	10f. Zip Code			10g. Citi	izen of What Coun	try?
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	ems 2	Funeral	11. Marital Status	2. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puert	ecify Yes or No- Rican, etc.)		14. Race - Americ Black, White,	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once.	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 █️No If Yes, Give Year or Dates:		1 □ Yes X□ No	Specify:			Specify: WI	HITE
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p	e file	Be (17. Father's Name (First, Middle, Last)				18. Mother's Nam			n Surname)	
yla	ould to Ment arked atic e	2	ROBERT STAPLES		1		ENDORA	REYNOLD		. T 00-1- 7-	0-4-1
Nar	12 sh hand rism traum		19a. Informant's Name/Relationship (Typ			ng Address (Street					
e,	1 and Health em 2 ther t		NANCY WEISS/DAUGH 20a. Method of Disposition	TER 20b	. Place of Dispo	58th AVE		Date ENSBURG,	20c. Lo	YLAND ZO ocation - City or To	0710 own, State
Baltimore,	ages ent of t: If It y or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Qther (Specify)	emoval from State		matory or other plac RANS CEME		7/2009	CHE	LTENHAM,	MARYLAND
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7	/Medical Examiner		resulting in death)	Due to (or as a cons	equence of):						
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68760,	ificate be executed g physician and as the burial-transit	edical	d								
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Box	leath cert attending	ian	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome pf pred 1□Live birth 2□F	etal death 3	Ectopic pregnanc	у			23d. Date of deliv Month	ery Day Year
0	The law requires that the death cer ate has been signed by the attendin page 2 should be detached for use	Physician/M	1 ☐ Yes 2 🗷 No 9 ☐ Unknown	4□Pregnant at time o 9□Unknown	ordeath 5	Other (specify)					
Δ.	uires that the de signed by the a Id be detached f		Part II. Other significant conditions con	tributing to death but not r	esulting in the u	ınderlying cause giv	ven in Part I.	23e. Did to	obacco	use contribute to t	he cause of death?
Vital Records,	uires n sign ild be	d by						1 🗆 '	Yes 2	2 □ No 3 □ Pro	bably 4 Unknown
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or V	<u>≅</u> .≅ ≤	10 E	1 ☐ Yes 2 No		ER/Outpatie	III JU DOA				6 ☐Other (Speci	fy)
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sio	Attending r death. ector: After by the fune	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of injury - A	thome farm s	1]Yes 2□No	28f Location (Street a	and Number or Rur	al Route Number.
Division	l or A after o Direc	Certification:	4 ☐ Homicide determined	building, etc. (Spe				City or To	wn, Stat	te)	
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Phys	iclan: To the best of my	knowledge, dea	th occurred at the t	ime, date and plac	e, and due to the	cause(s) and manner as	stated.
	n 24 h	Medical	(Check only 2 Medical Examination)	ner On the basis of exam and manner stated.	ination and/or i	nvestigation, in my	opinion, death occ	urred at the time,			
	To the To the Community	Σ	29b. Signature and title of certifier	6		29c. Licen				ate signed (Month,	
) A			11/	West 1			00901		JAA	VUAKY	0,2009
R	_10		30. Name and address of person who co		tem 23a) (Type PITAL		Cott	EVERIY	MY	JUARY 1	5
	St	ate		32. Registrar's Si	onature	UNIT	0,71	1-12/	12		
	Regist		31. Date filed (Month Day Year)	ma 13. 14	all						

		-	For State Registrar	State of Ma	•	partment of learning		d Mental Hy	giene Reg. N2 (009	03248
	Physici		1. Decedent's Name (First, Middle, Las					2. Date of De Month Januar	ath		3. Time of Death 7:57 P. M
	/Medic	al .	Pearl Marie Blo			4b. City, Town,	or Location of D			ounty of Death	
	Examin	er	949 Old River R		3	Friend	sville		Gai	rrett	
	Funeral Director		210-40-7793	7. Age □ M 2 X F 61	(In yrs. last birtho	Months Davs		Min. 8. Date of Bir (Month, Da Aug 14	th y, Year) 194	Cou	place (State or Foreign ntry) rland
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location					10d. Inside City Limits
	e Man	ctor	MD Garrett		Friends	ville			-		1∑Yes 2☐No
	with th	Funeral Director	10e. Street and Number 949 Old River Ro	d . Ant D-	3	10f. Zip Code 2153	1		10g. Citize	n of What Cou USA	intry?
	death ms 23	nerai	11. Marital Status	12. Was Decedent E Armed Forces?		13. Was Decedent of If Yes, specify Cul	Hispanic Origin	? (Specify Yes or No)- 14.	. Race - Amer Black, White	
920	d within 72 hours after death with the Maryland Jiene. r then "natural", or Items 23a or 28a-f ehow The Madical Evantiaer must be notified at	þ	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Ves 2 N If Yes, Give Year or Dates:	o Vietnam	1 ☐ Yes 2 🛣 No		dello i licari, cic.,	Sį	pecify:	white
Maryland 21215-0036	72 m	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	(0	ecedent's Usual Occu Give kind of work done fe. DO NOT use retire	during most of	f working	16b. Kind	of Business/Ir	ndustry
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yla	d 2 should the and Ment is and Ment is 10 marked traumatic e	2	George Henry Blo		19b A	lailing Address (Stree		Wilhelm	er City or T	Town State 7	in Code)
			Ginnie Sines, d								e, MD 21531
Baltimore,	permit. Pages 1 and Department of Heelth Important: If Item 27 eny Injury or other tonce.		20a. Method of Disposition 1 ☐ Burial 2 [X]Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		cemetery,	isposition (Name of crematory or other plants Side Crem		Date 26, 2009		ation - City or T Sville	
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9	eath certifice attending ph for use as ti	/Med	IF FEMALE:	23c. If yes, outcome	of pregnancy				22	d Data of dali	
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	uires that signed b id be deta	ρ	Part II. Other significant conditions of	ontributing to death b	ut not resulting in t	ne underlying cause g	iven in Part I.		tobacco use Yes 2 🗆		the cause of death?
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	To the Hospital c within 24 hours of To the Funeral D completely filled in	Medical (nysician: To the best niner: On the basis of and manner sta	examination and/						
	To ti withi To ti comp	M	29b. Signature and title of certifier	2001	20		L615	4	29d. Date	signed (Month	1. Day, Year)
		1	30. Name and address of person who			ype, Print)					
	Sta	ate	P. Daniel MIlle 31. Date filed (Month, Day, Year)	32. Registr	ar's Signature		KLand,	MD 21220			
	Regist	rar	JAN 26 20	109 Draw	w B. ,	parket					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 03249 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Alice Bond Mary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Year) Months Days Hours Min 1 M 2X F 2/26/1930 78 Director 213-42-9611 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits Department of Health and Mental Hygiene. Income are regard with the Maryla Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinet must be notified at once. 1 XYes 2 □ No Director Maryland Charles Waldorf 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 2005 Wingate Ct. USA 20602 Apt 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married XXMarried If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ Mo Specify: Specify: 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Cook Herbs Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Pickeral Roy Mary M. Pickeral 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15210 Regina Dr. Brandywine MD 20613 Linda Brown/ Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) © Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Peters Church Cem. 1/30/2009 | Waldorf, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Funeral Home PA, Aquasco MD 20608 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** rollD143 /Medical Que to (or as a consequence of): Examiner robro vascu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine vascular dispase burial-transit signed by the attending physician be detached for use as the buria iasotes Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð toi Wiro 2 No 3 Probably 4 Unknown icate has been si ; page 2 should b 1 □ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an 1 ☐ Yes 2 🗷 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Dipatient ဥ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide

P.O. Box 68760,

and

28a-f show

Pages 1 and 2 should be filed within 72 hours after

Maryland 21215-0036

altimore.

The law requires that the death certificate be executed of Vital Records, To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Division

certificate

State Registrar

Medical

erson who completed cause of death (Item 23a) (Type, Print)

and manner stated.

29c. License number 47867

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Binga. 4701

Randolph Road # 216. ROCKVILLE MD 20852. 3. Registrar's Signature

31. Date filed (Month, Day, Year, JAN 2 2 2009

4 Homicide

(Check only one)

29b. Signature and title of certifier

29a. Certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 0 0 9 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 21,2009 Jan. 0210 V. Bardales Carlos /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Wicomico jalisbur4 Rehab + Nursinacto Under 1 Year | If Under 24 Hrs., Birthplace (State or Foreign Country) 7. Age (In yrs. last bir hday) 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex **Funeral** Months Hours Days 1**X** M 2□ F 75 5-28-1933 Guatemala Director 592-58-0479 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City. Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Director Wicomico Salisbury 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ", or Items 23a or 2 caminer must be n 21804 USA Funeral 208 Snow Hill Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 X Yes 2 No Specify: Specify: Hispanic þ 3 ☑ Widowed 4 ☐ Divorced "natural", Guatemalan Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Construction 6 Carpenter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sanchez Norberta Aldana ပ Vincent 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Item 27 208 Snow Hill Road, Salisbury, Maryland 21804 Maria Iniestra - Daughter njury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition Department of Important: If It any Injury or conce. 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Crematory of Delmarva 1-22-2009 4 □ Donation 5 □ Other (Specify) Delmar, Delaware 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Bounds Funeral Home Pelissa 705 E. Main Street, Salisbury, Maryland 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Span. disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed aftending physician and for use as the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown signed by the at d be detached for 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 | Yes 2 | 1√10 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA P After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: s after deau. ral Director: Aft 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours at To the Funeral D 1 dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4. Robins isbury Jilliam M.D. IVIC State JAN 22 2009 Registrar

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygienes 03251 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician JAN 0810 2009 Ronald Lynn Banks /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death, Examiner SALIS64KG REGIONAL HICOMICS YENINSULA If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, **Funeral** Voor Days 1X M 2□ F 40 157-60-8364 New York Director Oct.2, 1968 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Exeminar must be notified at Director 1 ☐ Yes 2 🗷 No Fruitland MD Wicomico 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21826 USA 426 Cartwright Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 M No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify. Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "na any injury or other traumatic event, Inc. Mich. once. Elementary/Secondary (0-12) College (1-4or 5+) 11th Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Mabell Banks ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise L. Greene /Sister 426 Cartwright Ave. - Fruitland, MD 21826 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Springhill Memory Gardens Jan. 24, 2009 Hebron, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Salisbury, Maryland 21801 Jolley Memorial Chapel, P.A. -1213 Jersey Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed Lower burial-trar Due to (or as a consequence of) Box 68760. Physician/Medical the as attending IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ģ Day Year 5 Other (specify) P.O. signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 Z No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No the within 24 hours after deat To the Funeral Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 100677 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAlisbury Md SAKERI MD 3 CARROLL 32. Registrar's Signatura 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygien 2009 03252 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 0611 Arthur Eisenhower Buhrman 2009 ahuar /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Days Hours Months Min. Yrs. 64 217-42-9620 April 12,1944 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show 10a. State th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Event national be neithed at 1 ☐ Yes 2 🙀 No Director Sabillasville Frederick Maryland 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number with 21780 U.S.A. 16522 Sabillasville Road Funeral Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: þ White 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Mason 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Archie Buhrman Charlotte Misner ဨ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health 5710 Fort Richie Rd. Sabillasville, Maryland 21780 Department of Health Important: If item 27 any Injury or other tr. Kevin E. Buhrman (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition February 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Smithsburg, Maryland 1, 2009 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory : 22. Name and Address of Facility 21. Signature of Funeral Service Licensee J.L. Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Maryland 21783 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Cerchial disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Discask ONOWON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed ending physician and use as the burial-tranah Due to (or as a consequence of): P.O. Box 68760. attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate has b rector, page 2 sh 24a. Was an 1 ☐ Yes 2 ☑ No director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Pother (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) funeral 28d. Describe how injury occurred 27. Manner of Death 28b. Time of In anspor 28c. Injury at Work? 1. Natural 5 ☐ Pending investigation ours after death. neral Director: Af filled in by the fur 1 ☐ Yes 2 ☐ No MAZINA fro m 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 □ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 140 within 24 hours a

To the Funeral I

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0060 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) -AIL ID HET 31. Date filed (Month, Day, Year) 32. Registrar's Signature State EFR 0 5 2009 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First Middle Last 2. Date of Death Month Physician 2009 P^{M} 28. 1651 Ella L. Brown January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner E1kton Ceci1 807 Blake Road If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🖺 F Director 59 April 3, 1949 Maryland 220-62-3811 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Maryland Ceci1 E1kton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 807 Blake Road 21921 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 M∭ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: þ 3 X Widowed 4 □ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Cook Health Care Department of Health and Mental Hygir Important: If item 27 is marked other I any Injury or other traumatic event, III once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Cox ပ Louise Lyle 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dawn Cox/Daughter 804 B Village Circle, Newark, DΕ 20b. Place of Disposition (Name of cemetery, crematory or other place)
Griffith AUMP 20a. Method of Disposition Date 20c. Location - City or Town, State February 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill, MD 2009 Church emetery 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signature of Funeral Service Licensee 103 W. Stockton Street, Elkton, MD rismin 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** toull COVERNAL disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Exami Deupheral Vascul burial-trar Due to (or as a consequence of) physician s the burial Division of Vital Records, P.O. Box 68760 Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) ☐Yes 2☐No signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 4 Unknown 2 No 3 Probably 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an certificate has birector, page 2 si autopsy performed 1 □Yes 2 ☐No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 40 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: A 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours aft.

To the Funeral Dil

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 31. Date filed (Month, Day, Year) 32. Registrar's Sjgnature State FEB 0 5 2009 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 2009 Helen Irene Buser /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 1emorial Sep 17, 7. Age (In yrs. last birthday, **Funeral** 1 □ M 2 □ ¥ 215-26-9601 88 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show if than "natural", or Items 23a or 28a-f sho WV Mineral Ridgeley 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Rt. 1 Box 555 26753 USA by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 1 \(\text{Yes} \) 2 \(\text{No} \) Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 □ No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify Specify. white 3 ☐Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) if Health and Mental Hygiene. Item 27 Is marked other than other traumatic event, Inc. M. homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank Seeders Delcie Baker Seeders 2 19a. Informant's Name/Relationship (Type. Print)

M. Allen Buser 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Rt. 1 Box 487 Ridgeley WV 26753 son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Restlawn Memorial Gardens 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any Injury or ott 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State 1/24/2009 MD LaVale 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lie 22. Name and Address of Facility ral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a Part 1. Eyer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heat/failur List only one cause on each line.

Immediate Cause (Final disease of A condition resulting in death)

a. Due to (or as a consequence of): Approximate Interval Between Onset and Death **Physician** 5 da /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any least 10 minutes cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Exami physician and s the burlal-tran Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical signed by the attending of the detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Dav 5 C Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an director, page 2 s autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 🗆 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After thi 28a. Date of Injury (Month, Day, 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: / 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

30. Name and address of parson who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

4

ase Type or Print in Black indentite into an amend item in Maryland behaviored the Beautificate of Death

Cartificate of Death

Reg. No. 2009 03255 1. Decedent's Name (First Middle, Last) 2. Date of Death Month **Physician** 18, 2009 1:27 Cabrini J. Culley January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner CLINTON
If Under 1 Year | If Under 24 Hrs. PRINCE GEORGE'S SOUTHERN MARYLAND HOSPITAL CENTER 5. Social Security Number 577—7443 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Aug. 24, Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 □ M 2 🔼 F Min. 55 1953 Washington, D.C. Aug. Director Usual Residence of Decedent within 72 hours after death with the Maryland 10d. Inside City Limits 10a State 10h. County 10c. City, Town or Location "natural", or items 23a or 28a-f show office Examiner must be notified at Maryland Prince Georges Temple Hills Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2705 Keith Street United States 20748 Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒ No 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify. Š 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) College (1-4or 5+) Accounting Tech Government Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be i Health and Mental Helen John Alexander Mills 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau Gwendolyn Revell / Sister 8009 Vernon Dr. Ft. Washington, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Memorial Jan.24,2009 Suitland, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 2. Name and Address of Facility
Alexander S. Pope. P.A.
5538 Mariboro Pike/ Forestville, Md. 20747 M01085 aver 23a. Part Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMONIA **Physician** /Medical Due to (or as a consequence of): Examiner DISGASE ALTHU if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner PULMONARY DISEASE The law requires that the death certificate be executed HRONIC OBSTRUCTIVE Due to (or as a consequence of): burialphysician the burial Box 68760. ROGRESSIVE MYELOPATHY Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) P.O. I been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ STENOSIS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed EVERATIVE DISC 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No of Vital I or Attending Physician: after death. 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) funeral 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Division 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident To the Funeral Director; completely filled in by the 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital e Funeral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) within 2. and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9628 MARLBORD , UPPER MARLRORD PIKE 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

		•	For State Registrar	State of Ma	ırylan				ealth a Death			giene Reg. No.	.003	03	256			
	Physici	an	1. Decedent's Name (First, Middle, Last)								2. Date of De Month	Day			me of Death			
П	/Medic	al	Candies L Cook 4a. Facility Name (If not institution, give si	teret and number		-	4h Cih	Tour	Location	of Dooth	1 -		- 2009 County of De	_	00 ™			
4	Examin	er	Prince George Commu		pita:	1	'	rerly		OI Dea(II			ince G		5			
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. i	last birthday)	If Unde	r 1 Year	If Under	24 Hrs.	8. Date of Birth (Month, Day, Year) S-8-1918 9. Birthplace (State or Fo Country) North Caroli							
	Director		579-18-7702 1 ¹	M 2⊠F 90	0	Yrs.	Months	Days	Hours	Min.	5-8-19	18	Noi	cth Ca	rolina			
	pu »		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Insi	de City Limits			
	Manyla febo	ច	DC		Was	shingto	on Do	:						11	Yes 2□No			
	r 28a	rec	10e. Street and Number			3112119		p Code				10g. Citi	izen of What C	ountry?				
	th with	al D	1059 48th Street N	E				2001	19			Unit	ed Sta	tes				
	- dea	Funeral Director	11. Marital Status	2. Was Decedent E Armed Forces?		S. 13. V	Nas Dece f Yes, sp	dent of Hi	ispanic Or n, Mexica	igin? (Spe n, Puert <i>o</i> F	cify Yes or No Rican, etc.)		14. Race - An Black, Wh	rencan India	an,			
ဓ္က	filed within 72 hours after death with the Maryland Hygiene. Kher then "natural", or Iteme 23a or 28a-f ehow ent, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 反 Divorced	1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:	lo		1 ☐ Yes	2 ☑ No	Specify:				Specify: B	lack				
8	tural stural	ed	15. Decedent's Educ	ation		16a. Deced	ient's Usi	al Occupa	ation			16b. K	ind of Busines					
215	hin 72 Pm "ng Media	plet	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or 5	+)	(Give life. L	kind of w DO NOT	ork done d use retired	during most of working									
21	ad wit	Completed		2		Educ	atio	nal A										
nd n	be file	Be	17. Father's Name (First, Middle, Last)								(First, Middle	, Maiden	Sumame)					
<u>\Z</u>	s 1 and 2 should be filed within 72 hours after death with the Marylan fer Hellin and Mental Hygiene and the file marked other treatren "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ဥ	Thomas Lindsey 19a. Informant's Name/Relationship (Type	o Print)		10h Mailin	a Addros		Ida Martin and Number or Rural Route Number, City or Town, State, Zip Code)									
Ma	d 2 sl th an t7 ie r traur		Linda Greenfield/da			1	•					-	ille M		50			
ē,	s 1 and f Heelth item 27 other tr		20a. Method of Disposition		20b. P	Lace of Dispo emetery, cren	sition (Na	me of			ate		ocation - City o					
E O			1 XBurial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	4 Donation 5 Other (Specify) Fort Lincoln Cemetery									22-2009 Brentwood MD					
Baltimore, Maryland 21215-0036	permit. Page Department of Important: If any injury or pnce.		21. Signature of Funeral Service License	A) I	atte	22 24 34	Name a	nd Addres	s of Facili	^{ity} Fort ∝ Rd	Linco	ln F	uneral MD 207	Home				
	•		23a. Part1. Entor the disease, or complic shock, or heart failure. List only on	ations that caused e cause on each lir	the death								1110 . 207.	Approx	ximate al Between			
i	Physician		Immediate Cause (Final disease or condition	Septic	emia									Onset	and Death			
	/Medical Examiner		resulting in death)	Due to (or as a														
		-	Sequentially list conditions, if any, leading to immediate	Pneumo		uence of):								-				
	uted 1	Examiner	Cause (Disease or injury	Ventil			dent	Rest	irat.	orv E	ailure							
oʻ	exection and endingle in all-tra	Exa	that initiated events c. resulting in death) Last	Due to (or as a			acite	Res	1140	01,1	ar. are			1				
8760,	death certificate be executed e ettending physicien end id for use as the burial-transit	dicai	d															
9 ×	ertifica ling pl		IF FEMALE:	2- 11	of													
Вох	eath certific ettending p for use as	Physician/Me	in the past 12 months?	3c. If yes, outcome a 1 ☐ Live birth 4 ☐ Pregnant at	2 Feta	Ideath 3□	Ectopic (oregnancy					23d. Date of d Month	elivery Day	Year			
P.O.	that the de ed by the detached	ysic	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	9☐ Unknown	time or o	BOIII 3C	J Other (s	pociij)										
	The law requires that the site has been signed by the bege 2 should be detached.	by Pt	Part II. Other significant conditions con	tributing to death bu	ut not res	ulting in the ur	nderlying	cause give	en in Part	1.	23e. Did	tobacco u	use contribute	to the caus	e of death?			
rds	w require been sig should b	ed b	End Stage Renal Fa	ilure							10	Yes 2	© No 3□1	robably	4 Unknown			
Division of Vital Records,	e iaw requ has been je 2 shouk	Completed									24a. Was		24b. Were a	autopsy find	lings available			
œ =	The sate h	Com									perfe 1⊠ Yes	ormed?	death?	os 2□No				
/ita	iician: Th certificate rector, peg	Be	25. Was case referred to medical examiner?	ospital:				015		e of Death	Check only	one)						
of	Physi this c	2 2	1 ☑ Yes 2 ☐ No	1 ☐ Inpatie		ER/Outpatien 28b. Time of			4 14		ne 5 Res		6 ☐Other (Sp	ecify)				
0	ding h. After funer	tlon	1 X Natural 5 Pending 2 Accident investigation	(Month, Day	Year)	Injury	м	28c. Injun Work 1 □ 1	k? Yes 2□		od. Describe	now injui	y occurred					
18	or Attending Physician: after death. Director: After this certifict in by the funeral director.	flca	3 Suicide 6 Could not be	28e. Place of Inju			eet, facto	ry, office		2	8f. Location (Street an	nd Number or I	Rural Route	Number,			
5	s afte	Certification:	4 Hamicide	building, etc	с. (<i>Spac</i> it)	y)					City or To	wn, State	9)					
	o the Hospital or Attending Physician: The tithin 24 hours after death. o the Funeral Director: Affer this certificate hy impletely filled in by the funeral director, page	edical	29a. Certifier 1X Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of ar: On the basis of and manner sta	examina	wledge, death tion and/or inv	occurre vestigatio	d at the tim	ne, date ar pinion, dea	nd place, a ath occurre	nd due to the	cause(s) date and	and manner and displace, and di	as stated. Je to the ca	use(s)			
	within 2 To the	ž	29b. Signature and title of certifier				29	c. License	e number			29d. Da	te signed (Mo	nth, Day, Ye	ear)			
	_		Illelle	lupa	J_		I	2757	7			01/1	2/2009					
)	5		30. Name and address of person who con							D 00	705							
			Ophnell Cumberbatc 31. Date filed (Month, Day, Year)	22 Pagistes	rde Signa	tal Dr	. Ch	ever.	гу, М	<u>и</u> 20	785							
į	Sta Registi		JAN 2 2 2009 Sen	and John Stra	pa	المعكل												

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Reg. No 2009 Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 12 2009 5:50P M JANUARY CLAY CHATMAN RICHARD /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY SILVER SPRING HOLY CROSS HOSPITAL If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Year Hours 1**√** M 2□ F Yrs 214-08-0761 KANSAS 1969 14 JUNE Director 39 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show traumatic event, the Medical Examinar must be notified at 1X Yes 2 No Director WASHINGTON DC 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō USA 20009 1811 IRVING STREET N.W. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ∐Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō Specify: 1 □ Yes 2√∑ No BLACK Specify: 2 3 Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE DISABLED 10th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) be 1 Be MARTHA YOUNG RICHARD CHATMAN III ဂ္ and f 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2100 HIGHWAY 15LOT7 MYRTLE BEACH, SOUTH CAROLINA 29577 27 MARTHA PRESSLEY/MOTHER other 1 permit. Pages 1 and Department of Heall Important; If item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/16/2009 RIVERDALE, MARYLAND RIVERDALE CREMATORY J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 7474 LANDOVER RD LANDOVER, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician BIL PNEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner CARDIOMYOPATHY Sequentially list conditions, Due to for as a consequence of Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed and as the burial-trar Due to (or as a consequence of): Box 68760, physician Physician/Medical attending post of the season o IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) s been signed by the should be detached Division of Vital Records, P.O. 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 21☑ No 3 ☐ Probably 4 ☐ Unknown AIDS Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an SEPSIS cate has t autopsy performed? (es 2 No 2 No 1 ☐ Yes 26. Place of Death (Check only one) director, 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) funeral 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 24 hours after death Funeral Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. within 2 To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 14, 2009 JANUARY D60826 30. Name and address of person who completed cause of geath (Item 23a) (Type, Print) 1500 FOREST GLEN ROAD SILVER SPRING, MARYLAND 20910 KSHAMA GARG M.D 32. Registrar's Sign 31. Date filed (Month, State JAN23 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Januar CARTER ROGER 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death PRINCE GEORGE'S LANHAM DOCTOR'S HOSPITAL 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) Year) Months Days Hours Min. 1 ₹ M 2 □ F 82 579-24-5389 10 1926 WASHINGTON, DC APRIL Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10h County LANDOVER 1X Yes 2 No PRINCE GEROGE'S 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20785 3421 DODGE PARK ROAD # 202 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ NoARMY If Yes, Give Year or Dates: 14. Race - American Indian 11. Marital Status 1 □ Never Married 2 □ Married BLACK 1 ☐ Yes 2 TNo Specify Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE 12th MECHANIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) FLORENCE L. CARTER ROY M. CARTER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3421 DODGE PARK ROAD # 202 LANDOVER, MARYLAND 20785 GWEN PITMAN/DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GEORGE WASHINGTON CEM. 1/30/2009 ADELPHIA, MARYLAND J. B. JERKINS FUNERAL HOME 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal deat
4 Pregnant at time of death 2 Fetal death 3 🗆 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? **significant conditions** contributing to death but not resulting in the underlying cause given in Part I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner

and

peen

has

certificate

The law requires that the death certificate be executed

Box 68760,

P.0.

Division of Vital Records,

Physician:

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

Completed by

Be

ౖ

Funeral

Director

28a-f show

Department of Health and Mental Hygiene. Important: fittem 23a or 28a-f show important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Its. Medical Experient must be maitifued at

Baltimore, Maryland 21215-0036

and 2 should be

Examiner Physician/Medical ģ Completed Be ٩

burial-transit attending physician for use as the buria signed by the a d be detached fi page 2 should To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Certification:

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

> 24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of

1 ☐ Yes 26. Place of Death (Check only one)

LOCK KOAD

24 No

25. Was case referred to medical examiner? Hospital: 1 ☐ Yes 2 ☐ No 27. Manner of Death

1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28h. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 ☐Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29a. Certifier (Check only one)

1X Natural

2 Accident

3 Suicide

4 Homicide

to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and manner stated.

29b. Signatur certifie

5 Pending investigation

6 ☐ Could not be

(Type, Print) completed cause of deat ess of person

State Registrar

Medical

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygienes For State Registrar Certificate of Death 2. Date of Death Time of Death . Decedent's Name (First, Middle, Last) Day Year Month **Physician** arpenter 2009 AM 5:21 ons Jan /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baismore university of Maniland Medical Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 27, 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days Months 88 1920 Washington, DC 579-14-4281 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f shov ral", or items 23a or 28a-f shov 1 ☐Yes 2 No Director Kearneysville WV Jefferson 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 25430 USA 199 Sunflower Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after on the sith and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: White 2 3 ₩ Widowed 4 □ Divorced natural Completed er than "natur, Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 27 is marked or traumatic ev Mildred Hobbs William Randolph Spahr ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 199 Sunflower Drive, Kearneysville, WV 25430 Marsha Krashoc / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Department of the Important: If ite any injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 1/23/2009 Fort Lincoln Cemetery Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Fune Service/Licensee 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Wema disease or condition resulting in death) /Medical Due to (or as a consequence of): lute on chronic renal tallure Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury ne Hospital or Attending Physician: The law requires that the death certificate be executed Exami physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗌 Ectopic pregnancy Month Year 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 110 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 □ No 2 ER/Outpatient 3 DOA 1 ☐ Yes 1 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Whatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: d in by the 6 □Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie AU4176435A18120 Jan, 20, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 S. Greene Street Date filed (Month, State JAN 2 3 2009 Registrar

	-	For State of Maryland 1 - State Registrar	•	rtment of H tificate of L			jiene leg. No. (2009	03260
Physicia /Medic	_	1. Decedent's Name (First, Middle, Last) William R. Ceresa, Jr.		_		2. Date of Dea Januar		, 2009	3. Time of Death 7:40A . M
Examin	er	4a. Facility Name (If not institution, give street and number) Laurel Regional Hospital		Laurel	Location of Death		Pr	cince Ge	
Funeral Director		5. Social Security Number 294-30-1378	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Nov • 20	, 19 26	9. Birthp	place (State or Foreign ptry)
Maryland -f show	tor		Town or Loc					1	0d. Inside City Limits 1 □ Yes 2 X No
h with the 23a or 28a st benoti	Funeral Director	10e. Street and Number 11410 Blueridge Drive		10f. Zip Code 20705			-	en of What Cour ted Stat	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Iniportant: I fitem 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Madical Evan instraint to a the natified at once.	þ	11. Marital Status 1 □ Never Married 2 M Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give WWII		Vas Decedent of H FYes, specify Cuba □Yes 2 ☑ No	ispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- pecify Yes or No- pecify Yes or No-		4. Race - Americ Black, White, of Specify: Wh	ean Indian, etc. oite
within 72 ho ene. than "natur	Completed	(Specify only highest grade completed)	(Give I life. E	lent's Usual Occup kind of work done o OO NOT use retired al Illus	during most of work d)	king		d of Business/Ind	overnment
ald be filed Aental Hygi rked other tic event, I	To Be Co	17. Father's Name (First, Middle, Last) William R. Ceresa, Sr.			18. Mother's Nam		Maiden S	Gurname)	
and 2 shore ealth and h		Rose Marie Ceresa -wife	11410	g Address <i>(Str</i> eet) Bluerid	ge Drive	Beltsvi	11e,	Mərylər	nd 20705
Pages timent of Hitant of Hitant of Hitant of Hitant lant: If iten			of H		metery 1/		Silv		own, State Ing, Marylar
permit Depart Import any inj		21. Signature of Funeral Service Licensee Locald V. Bryward	44		<u>r Mill Ro</u>	<u>oad Belt</u>	svil.	ne, PA le, Mary	/land 20705
Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Chroni Due to (or as a consequer	c Res	piratory	Failure				Approximate Interval Between Onset and Death
ficate be executed by physician and sthe burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Chronic Obstr Due to (or as a consequence of the consequence o	nce of):	re Pulmon	ary Disea	ese exac	erbə	tion	
The law requires that the death certificate has been signed by the attending phage 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal dr 4 □ Pregnant at time of dea	eath 3	Ectopic pregnanc Other (specify)	у		23	3d. Date of delive	ery Day Year
quires that	þ	Part II. Other significant conditions contributing to death but not resulting	ing in the ur	nderlying cause giv	en in Part I.		bacco us es 2□		he cause of death? bably 4 🛣 Unknown
	Completed					24a. Was autop perfo		prior to co	opsy findings available ompletion of cause of 2 🛣 No
hysician: Th his certificate I director, pag	To Be	25. Was case referred to medical examine? 1 \(\text{Yes} \) 2 \(\frac{1}{N} \text{No} \) Hospital: 1 \(\text{Inpatient} \) 2 \(\text{EF} \)	R/Outpatien	t 3 DOA Oth	26. Place of Dea er: 4 ☐ Nursing H	th <i>(Check only</i> o ome 5□ Resid		☐Other (Specia	fy)
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	1 🕅 Natural 5 Pending (Month, Day, Year) 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At hom.	8b. Time of Injury e, farm, stre	M 1 🗆	yat k? Yes 2 ∐ No	28d. Describe h	Street and		al Route Number,
ospital or hours after uneral Dire		4 ☐ Homicide building, etc. '(Specify) 29a. Certifier (Check only 2 ☐ Medical Examiner: On the basis of examination					cause(s)		
To the H within 24 To the Fi complete	Medical	one) and manner stated. 29b. Signature and title of certifier		29c. Licens	e number		29d, Date	signed (Month,	Day, Year)
12		30. Name and address of person who completed cause of death (Item 2						uəry 21	, 2009
Sta		Mythily Vancha, M.D. 7300 Van Du 31. Date filed (Month, Day, Year) JAN 22 2009	re		el, Mary	land 207	07		
Registr	ar	JAN 2 2 2009 Cetur S.	god	ites					

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 0250 2009 18 Cherot Harrison /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HICOMICO SALISBURY TENINSULA REGIONAL MEDICAL Conter If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Year) Months Days Hours 1 X M 2 □ F 6-25-1926 Conneticut Director 055-22-7792 82 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 X No Director Salisbury MD Wicomico 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21801 USA 5567 Channel Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑Yes 2 ☐ No 194 14. Race - American Indian, 11. Marital Status Black, White, etc. 1943-1 ∑Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. Specify 1946 ģ 3 Widowed 4 Divorced Native American 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Plastic Design Engineer Pharmaceutical 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harrison Cherot Louise ၉ Romero 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5567 Channel Drive, Salisbury, Maryland 21801 Olga Cherot - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Crematory of Delmarva 1-21-2009 Delmar, Delaware 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bounds Funeral Home 21. Signature of Funeral Service Licenses 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** へ disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease o, Injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 ☐Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 X No 1 VInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident within 24 hours after death
To the Funeral Director:
completely filled in by the 6 Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of H50497 1/18/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SA UISBUM Chris 100 E. 7_{Day, Year)} JAN 2 2 2009 32. Registrar's Signature 31. Date filed (Month) State Barks Registrar

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 7:55 a M Richard Draper 21, 2009 Francis January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring 3160 Gracefield Road, Apt. 1513 Prince George's If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Yea April 11, 9. Birthplace (State or Foreign Country)
Indiana 6. Sex 7. Age (In yrs. last birthday) Social Security Number **Funeral** Min. Months Days Hours 1**1** M 2□ F 577-10-9398 94 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show r than "natural", or items 23a or 28a-f shov 1 ☐ Yes 2 No Director Maryland Prince George's Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20904 3160 Gracefield Road, Apt. 1513 USA Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: Specify Specify: White 3€XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) مه filed س. ۱۰ Hygiene. ۱۳ than ۳۰ Elementary/Secondary (0-12) College (1-4or 5+) Administrative Officer Federal Government h and Mental Hygie 7 is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Leon Harold Draper Julia Anna McMahon ၉ other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 907 Lord Granville Drive, Morehead City, NC 28557 Kathleen D. Kirk/Daughter item 27 i Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Department of Important: If its any injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Jan. 26 Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2009 Silver Spring, Maryland Name and Address of Facility 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd., W., Silver Spring, MD 20901 Cooling 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a Pancreatic Cancer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed burial-transit and Due to (or as a consequence of) P.O. Box 68760. After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy 1 □ Yes 2 No Division of Vital spital or Attending Physiclan: Thous after death.
neral Director: After this certificat y filled in by the funeral director, ps 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital within 24 hours a 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number d36716 January 21, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew Kundran, MD 3110 Gracefield Road, Silver Spring, MD 20904 31. Date filed (Month, Day, Year) Registrar's Signature State JAN 22 Registrar

Draper

1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** mary 16, 2009 Edward John Dumolo /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** VAMaryland Weath Care
5. Social Security Number 6. Sex 7. A Perry 8. Date of Birth **Funeral** Months Days Hours 1 🕅 M 2 🗆 F 099-18-0683 **Director** Aug. 20, 1924 New York Usual Residence of Decedent the Maryland 10b. County 10c. City. Town or Location ral", or items 23a or 28a-f shov Examiner must be notified at Director Maryland Cecil Perryville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21903 United States 100 Greenway, Apartment 308 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 □ Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Jame Khaun to Physician: () 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 "natural", or If Yes, Givers 1 ☐ Yes 2 🙀 No Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Technician Computers 7 is marked other traumatic event, 1 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carmela Fusco John Dumolo ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21903 19a, Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s
Department of Health as
Important: If item 27 is
any injury or other trau
once. Gloria Dumolo / Spouse 100 Greenway, Apartment 308, Perryville, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition January 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 Mayerdale Crematory Newark, Delaware 21. Signature of Buneral Service Licenses 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 23a. Part 1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to r as a consequence of): Examiner 1 Nere Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and stell filled in by the funeral director, page 2 should be detached for use as the burial-transit ronic Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy 5 Other (specify) I∐Yes 2 □ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. Was an

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🎉 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy 1 ☐ Yes 2 Wo 1 ☐Yes 2 MoNo 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) Melecia Santos, M. D., YA Maryland Nealth Care System, Perry Point, MD 21902

23d. Date of delivery

Day

10:43 RM

Birthplace (State or Foreign Country)

14. Race - American Indian,

Black, White, etc.

Specify: White

10d. Inside City Limits

Approximate Interval Between Onset and Death

CUNKNOWN

MUNDOROL

11∑Yes 2 □ No

6+IVA

To the Hospital or within 24 hours aft To the Funeral Di completely filled in

State Registrar

Be

Medical Certification: To

31. Date filed (Month, Day,

29b. Signature and title of certifier

25. Was case referred to medical examiner?

5 Pending investigation

6 ☐ Could not be

1 | Yes 2 | **3**000

27. Manner of Death

1 Natural

2 Accident 3 🗌 Suicide

4 ☐ Homicide

29a. Certifier (Check only one)

1 - For State Registrar

32. Registrar's Signa backe

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work?

29c. License number

1 ☐ Yes 2 ☐ No

28a. Date of Injury (Month, Day, Year)

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

13281 State

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

Road

		State of Maryland / De	partment of Health and M	lental Hygiene	00005
		- negatai	ertificate of Death	Reg. No. 2 ()	03265
Physicia		1. Decedent's Name (First, Middle, Last) Barbara G. Dziekiewi	CZ	Jan 18, Day 2009 Year	3. Time of Death 4:41 A. M
/Medic Examin		4a. Facility Name (If not institution, give street and number) Southern MD Hospital	4b. City, Town, or Location of Death Clinton	4c. County of De	George's
Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthd)	Months Dave Hours Min	8. Date of Birth 9. B	irthplace (State or Foreign Country) ashua, NH
Director		115 30 1250		May 15, 1940 N	ashua, Nn
aryland show	ř	10a. State 10b. County 10c. City, Town or			10d. Inside City Limits 1 □ Yes 2 ☑ Voto
the Mi 28a-f	Director	Maryland Prince George Upper 10e. Street and Number	Marlboro 10f. Zip Code	10g. Citizen of What C	
h with 23a or		8511 James Street	20772	9	States
ours after death with the Marylan purs after death with the Marylan rai", or items 23a or 28a-f show Exaction on the configuration of t	Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ ☒ No	3. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.) 14. Race - An Black, Wh	
should be filed within 72 hours after death with the Maryland and Meril Hygiene. The Hygiene is marked other than "natural", or items 23a or 28a-f show umatic event, it a fredict Examination in the motified at	ρ	3 ☐ Widowed 4 ☐ Divorced	1 ☐Yes XXNo Specify:	Specify:	White
be filed within 72 ho tal Hygiene. d other than "nature event, it a medical	Completed	(Specify only highest grade completed) (G	ecedent's Usual Occupation live kind of work done during most of work ie. DO NOT use retired)	ing 16b. Kind of Busines	s/Industry
4. With yearing 2 1. Lind with and 2 should be filed with the death and Mental Hygene. Hen 27 is marked other than other traumatic event, Italia.	Som	Elementary/Secondary (0-12) College (1-4or 5+) Pr	eschool Teacher	Child C	are
be file	Be	17. Father's Name (First, Middle, Last) Robert Young		(First, Middle, Maiden Surname)	
th and Mer	ဥ		ailing Address (Street and Number or Rur	treppone	Zin Code)2 0 7 7 2
12 th a 7 is			8511 James Stree		
		20a. Method of Disposition 20b. Place of Discernetery, and Permanent from State	sposition (Name of crematory or other place) Jan 23		
permit. Pages Department of Important: If it any injury or o		4□Donation 5□Other (Specify) Resurr	ection Cemețery	Clinton,	Maryland
Deparm Deparm any is		21. Signature of Funeral Service Licensee	22. Name and Address of FacilityLee Alexandria Ferry		
		23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition resulting in death) a. Septicama			Onset and Death
/Medical Examiner		Due to (or as a consequence of):			
it. d	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
xecute and Ftrans	Examiner	Cause (Disease or injury that initiated events c			
cate be executed physician and the burial-transit	dical E	d			
D & € €	Medi	IF FEMALE:			
To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death. Of the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 22 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 9 Unknown 1 1 1 1 1 1 1 1 1	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of common Month	lelivery Day Year
o, F.s.	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacco use contribute	to the cause of death?
w requires to been signer should be considered.	ted b	ESRD, B-cell lymphoma,	tortic steniosis	1 Yes 2 No 3	Probably 4 Unknown
e law r has be	ompleted	Peripheral Vascular disease	, hangrene	24a. Was an autopsy performed 3 death	autopsy findings available o completion of cause of
hysician: The la	e Co	Pleural elkison. 25. Was case referred to madical	OS Plane of Deat	1 □ Yes 2 □ No 1 □ Ye	es 2 No
ysicia ysicia is cert	0 B	examiner?	Other:	n <i>(Check only one)</i> ome 5 ☐ Residence 6 ☐ Other <i>(S)</i>	pecify)
ding Phys h. After this funeral dir	on:T	27. Manner of Death 28a. Date of Injury 28b. Time (Month, Day, Year) Injury Injury 1,000 Injury	ne of 28c. Injury at Work?	28d. Describe how injury occurred	
ttendii death. tor: A the fu	icati	2 Accident investigation 3 Suicide 6 Could not be 280 Place of Injury - At home form	M 1 Yes 2 No	28f. Location (Street and Number or	Pural Poute Number
al or A s after il Direct	Certification:	4 ☐ Homicide determined building, etc. (Specify)	, altoot, factory, office	City or Town, State)	narai nodie ivamoci,
To the Hospital or Atlandi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical (29a. Certifier (Check only one) ACCertifyIng Physician: To the best of my knowledge, c 2 Medical Examiner: On the basis of examination and/a and manner stated.	eath occurred at the time, date and place or investigation, in my opinion, death occur	and due to the cause(s) and manner red at the time, date and place, and d	as stated. ue to the cause(s)
To ti withi To ti com	Ž	29b. Signature and title of certifier	29c. License number D63183	29d. Date signed (Mo Jan 20	nth, Day, Year) • 2009
)		30. Name and address of person who completed cause of death (Item 23a) (Ty		- Juli 20	,
BB5		VITAY CHOI VANIMANT 7503 CLOPE	PATTS ROAD (L	CM - NOTNI	20735
Sta Registr		31. Date filed (Month, Day, Year) JAN 2 2 2009 A Registrar's Signature	in Ked		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Shirley May Dittmer /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 24 Hrs. 8. Date of Birth Min. Month, Day, June 22, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 1 F 69 Months Days Hours Pennsylvania 209-30-8141 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Modical Examiner must be notified at 1 ☐ Yes 🏖 ☐ No Director Mt. Savage MD Allegany 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21545 U.S.A. 13512 Bowman's Lane · death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 2 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) alth and Mental Hygiene. 27 is marked other than "r r traumatic event, the Med Elementary/Secondary (0-12) College (1-4or 5+) Hearning Self-employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi and Mental h Mary Laura (Boswell) King John King ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 to Department of Health an Important: If item 27 is any Injury or other traus 4 Allamong Lane, Morgantown, WV 26508 Robin Falor Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 € Burial 2 Cremation 3 Removal from State Frostburg Memorial Pk Feb 5, 2009 Frostburg, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Funeral Service, 1302 Natl. Hwy. 21502 Part L Enter the disease, of complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death 23a. Part 1/Enter the disease, Immediate Cause (Final disease or condition resulting in death) **Physician** SEP Days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Examiner burial-transi and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 5 ☐ Other (specify) signed by the a ☐Yes 2☐No 9**⊠**Unknown 23e. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown icate has been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en performe certificate 1 □Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No npatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

The law requires that the death certificate be executed Box 68760, P.0. Division of Vital Records, ne Hospital or Attending P n 24 hours after death. he Funeral Director: After t pletely filled in by the funera To the I within 2

Baltimore, Maryland 21215-0036

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29b. Signature and title of certifier

4 Homicide

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Osei-Bownin Emmanue

and manner stated

01-31-2009 10062929 500 Memorial Avenue #105 cumberland MD 21502

State Registrar

Medical

31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB U Lensur

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State of Maryland / Department of Health and Mental Hygiene For State State Registrar/MFND#29dperMD1/22/09, BMW, MbCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 4:00 AM **Physician** SIDNEY 01 15 200 FRIEDRIZH /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner COUNTY COLUMBIA - M If Under 1 Year | If Under 24 Hrs. HOWARD GENERAL 140511 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months Days Hours 1⊠M 2□F New York January 12, 1922 Director 075-16-4826 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Everations of use to rectified at 1 ☐ Yes 2 No Director Columbia Maryland Howard 10f. Zin Code 10g, Citizen of What Country? 10e. Street and Number 21044 ILS.A. 5400 Vantage Point Road, #313 by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 ☐ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 🗵 No If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced White WWII Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: filem 27 is marked other than any Injury or other traumatic. Elementary/Secondary (0-12) College (1-4or 5+) Systems Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lena Klein ဂ္ Isador Friedrich 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5400 Vantage Point Road, #313, Columbia, Maryland 21044 Ethel Friedrich - Wife Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 01/18/2009 Columbia, Maryland Columbia Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licer see 22, Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** neumonic /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit denou Avilie Due to (or as a consequence of): P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 1 □Yes 2 ☑ No 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 1 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 01/15/09 067127 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CEDAR COLUMBIA - MD. AMABO 31. Date filed (Month, Day, Year) 22. Registrar's Signature State Registrar

			_ FUI	artment of Health and Ment rtificate of Death	Reg. Na. 009	03268
	Physici /Medic		Decedent's Name (First, Middle, Last) Eli W. FLEMIN	C N	nuary 18, 2009	
	Examir		4a. Facility Name (If not institution, give street and number) 3142 Gracefield Road #319 5. Social Security Number 6. Sex. 7. Age (In yrs. last birthday)	4b. City, Town, or Location of Death Silver Spring If Under 1 Year If Under 24 Hrs. 8, D		Georges
	Funeral Director		107-18-1402 1 □XM 2□ F 82 Yrs. Usual Residence of Decedent		ne 10, 1926 Ne	irthplace (State or Foreign Country) PW YORK
	parmit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or Itams 23a or 28a-f show importent: If item 27 is marked other the Medical Examination of the December of the Medical Examination of the December of the Medical Examination of the December of the Medical Examination of the December of the Medical Examination of the December of the Medical Examination of the December of the Medical Examination of the Medical Examin	ector	Maryland Prince Georges Sil	ver Spring 10f. Zip Code	10g. Citizen of What 0	10d. Inside City Limits 1 Tyes 2 No
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9600	nours after urel', or Ital	d by Fur	1 Never Married 2 Married 1 XYes 2 No If Yes, Give Year or Dates: WW II	1 ☐ Yes 2 ☐ XNo Specify:	Specify:	vhite
21215-0036	filed within 72 h Hygiene. other than "neti ent, the Medica	Completed by Funeral Director	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation Is kind of work done during most of working DO NOT use retired) CONNEY	16b. Kind of Busines	s/Industry
Maryland 2	ould ba filed and Mental Hygist narked other natic svent, III	To Be C	17. Father's Name (First, Middle, Last) Isadore Flaumenbaum	18. Mother's Name (Firs	st, Middle, Maiden Sumame) a Levine	
	1 and 2 sho Health and I sem 27 is me		Lawrence Fleming, Son 401 H	ing Address (Street and Number or Rural Rould Ro	y, NJ 07110	
Baltimore,	parmit. Pages 1 Department of H Importent: If ite any injury or ot		'4 □ Donation 5 □ Other (Specify) Mt. Lebal	non Cemetery 01/21/0	9 Adelphi,	
Ba	Deparming Department of the services once.			.2. Name and Address of Facility Orchinsky Hebrew Fune 54 Carroll St., NW, W Iter the mode of dying, such as cardiac or resp	lashington, DC	20012 Approximate Interval Between
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Division	Jing After fune	Certification:	27. Manner of Death 1 X Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time Injury 28b. Place of Injury At home, farm, s	Work? 1 □ Yes 2 □ No Virget, factory, office 28f. L	ocation (Street and Number or P City or Town, State)	Rural Route Number,
	To the Hospitel or Attent within 24 hours after death To the Funerel Director; completely filled in by the	Medical C	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, deal (Check only one) 1 Medical Exeminer: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, and d nvestigation, in my opinion, death occurred at	lue to the cause(s) and manner a the time, date and place, and du	as stated. re to the cause(s)
10	2 +1	Σ	29b. Signature and title of certifier A Calc M. D	29c. License number D 50678	29d. Date signed (Mor	
-			30. Name and address of person who completed cause of death (Item 23a) (Type Rajeev Batra, M.D., 11120 New Hampsh	ire Ave, #300, Silve	r Spring, MD 2	20904
	Sta Regista		31. Date filed (Month, Day, Year) JAN 2 2 2009 Sentra A. Aa	VES.		

DHMH 17 Rev 1/2001

		State of Maryland / Department of Health and Months State Certificate of Death	, ,	giene Reg. No.2009	03269
			2. Date of Dea	3	3. Time of Death
Physiciar /Medica		Pauline Collette Fitzpatrick	Month Januar	Day Year Year Y 20, 2009	
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		Montgomery General Hospital Olney		Mo	ntgomery
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. O31-24-4350 1□ M 2対 F 75	8. Date of Birth (Month, Day July 8	9. B	irthplace (State or Foreign Country)
Director	-	031-24-4350 1	July 8	, 1933 M	assachusetts
rland ow		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Mary a-f sh	į	Maryland Montgomery Silver Spring			1 □Yes 2 🛣 No
or 288	Director	10e. Street and Number 10f. Zip Code	1	log. Citizen of What C	Country?
th will	2	3200 N. Leisure World Blvd., Apt. 602 20906		USA	
033 III'', o	by Fu	11. Marital Status 1 □ Never Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes ★▼ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify: 1 □ Yes, specify Cuban, Mexican, Puerto Force) 14. Was Decedent of Hispanic Origin? (Specify: 1 □ Yes, specify Cuban, Mexican, Puerto Force) 15. Was Decedent of Hispanic Origin? (Specify: 1 □ Yes, specify Cuban, Mexican, Puerto Force) 16. Was Decedent of Hispanic Origin? (Specify: 1 □ Yes, specify Cuban, Mexican, Puerto Force)	cify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify: W	ite, etc.
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Event To Bo. Complised Long.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business	
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re, s 1 ar if Hea item item	7	20a. Method of Disposition 20b. Place of Disposition (Name of Date of Disposition (Name of Date	20c. Location - City o		
altimore, mit. Pages 1 ar spartment of Hee portant: If Item: y injury or other		#ŒBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) **Community or other place) **Arlington National** Feb.		Arlington	, Virginia
alti mit. partm partm yorta / inju	İ	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins	9_ '	_	
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S8760, Medical ficate be executed britishing and street britishing in the burial-transit street british in the burial-transit street british british british british british british british british british br	oicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Entire Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):			
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the Madrical Certification. To Be Completed by Physician Medical Certification.	Ilysicianimed	23c. If yes, outcome of pregnancy in the past 12 menths? 1 Yes 2 No 9 Unknown Unknown Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) 9 Unknown 5 Other (specify) 9 Unknown 9 Unkno		23d. Date of d	elivery Day Year
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ithin 24 hours the Funers of the Funers ompletely fills	iealcal	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner stated.	d at the time, d	ate and place, and du	ue to the cause(s)
O TO SOUND IN		29b. Signature and title of certifier 29c. License number D 37 6 3 5		9d. Date signed (Mon	70, 7009
State		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 22. Registrar's Signature	~5y,	wa so	832
Registrar		JAN 22 2009 Senter B. Jakes			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Alice Virginia Finn January 20, 2009 6:25A. 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Greater Laurel Rehabilitation Center Laurel Prince George's 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month Pay 1933 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours Min 1 □ M 2 🖫 F 75 Washington, DC 579-40-2621 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Mərylənd Carroll Sykesville 1 □Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 915 Black Spruce Lane 21784 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ▼ No Specify: White Specify: 3X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary C&P Telephone Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Norval Stone Herbert Alice Olivia Norfolk 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 915 Black Spruce Lane Sykesville, Maryland 21784 Charles D. Finn -son 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Metropolitan Crematory 1/24/2009 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 21. Signature of Funeral Service Licensee Bonald Adres Borgwardt Funeral Home, PA ald 4400 Powder MiIl Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Arterio Sclerotic Cardiovascular Disease year Due to (or as a consequence of): Diabetes Mellitus Due to (or as a consequence of): Due to (or as a consequence of):

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

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Completed

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10a. State

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, its Modical Evantines must be notified any opice.

Baltimore, Maryland 21215-0036

with the Maryland

Examine

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Attending Physician: The law requires that the death certificate be executed

Hospital or

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Division of Vital Records, P.O. Box 68760,

signed by the attending physician and be detached for use as the burial-trar nours after death.

neral Director: After this
filled in by the funeral di To the Hospital within 24 hours a To the Funeral C

Physician/Medical ۾ Completed Be ၉ Certification:

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last yes, outcome of pregnancy
□ Live birth 2 □ Fetal death
□ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy Month 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Dehydration 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2**X** No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier

4 Homicide

and manner stated. 29b. Signature and title of certifier

29c. License number

D24721

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

January 21, 2009

Year

Day

2XINo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Syed A. Sadiq, M.D. 14333 Laurel Bowie Road, #208 Laurel, Maryland 20708

State Registrar

Medical

31. Date filed (Month, Day, Year) JAN 22



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Arthur William Fihelly 4:17 A.M January 19, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Southern Maryland Hospital Center Clinton Prince Georges 8. Date of Birth (Month, Day, Year)
April 15,1936 Washington, D.C. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 X M 2 □ F 577-50-9912 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Examination be notified at MD Prince Georges Upper Marlboro Director 1 TXYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5618 North Marwood Blvd. 20772 United States Funeral death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Pages 1 and 2 should be filed within 72 hours after of the sound Mental Hygiene.
ant: If item 27 is marked other than "natural", or ite 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No \$ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nuclear Engineer Federal Government 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur Thomas Fihelly permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev Stella Crone 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5618 North Marwood Blvd., Upper Marlboro,MD 20772 Linda Dean Fihelly/Wife 20b. Place of Disposition (Name of cemetery, crematory or aher place).
Geo. Wash. University
Medical Center 20a. Method of Disposition 20c. Location - City or Town, State Jan. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Washington, D.C. 4X Donation 5 ☐ Other (Specify) 2009 22. Name and Address of Facility Columbia Mortuary Services, P.A. 21. Signature of Funeral Service Licensee 9013 Annapolis Road, Lanham, MD 20706 mi taras 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final EREBROVASCULAR **Physician** disease or condition resulting in death) /Medical ue to (or as a consequence of) Examiner ATRIAZ if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) and physician a Due to (or as a consequence of) Box 68760, certificate be Physician/Medical attending pl IF FEMALE ves, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 🗆 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ed by the a P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, 3 The law requires CARDIOMYOPATHY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ▶No 24a. Was an has autopsy performed? Yes 2 No page certificate Division of Vital 1 □ Yes After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural
2 Accident 5 ☐ Pending investigation To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one)

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

22

/WD

30. Name and address of person who completed Gause of death (Item 23a) (Type, Print) Venkat S. Ramanan, 7501 SVC (LA17) (OA) # 307 UNTON

29c. License number

D53885

29d. Date signed (Month, Day, Year)

2009

		State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2009 0327	2
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r 28e-f sh	Director	MD Worchester Westover 10f. Zip Code 10g. Citizen of What Country?	No
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ed ala be	To Be	17. Father's Name (First, Middle, Last) Anthony McBride 18. Mother's Name (First, Middle, Maiden Sumame) Harriett S. Corbin	
Ma dd 2 :: ith av trau trau	Q.	19a. Informant's Name/Relationship (Type, Print) Great 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19c. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	27]
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imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nant of Heath and Mental Hygiene fine within 72 hours after death with the Maryland nant. If lien 27 is marked other than "natural", or items 23a or 28a-f sho for or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 N	Married Armed F	cedent Ever in U.S Forces? 2 X No	S. 13. W	/as Decede Yes, speci	ent of Hisp fy Cuban,	anic Origin? (Sp Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - American ite, etc.	Indian, Black,
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212 nould'be nd Ment is mark	TO B	19a. Informant's Name/Relation	nship (Type, Print.)		19b. Maili	•	`	and Number or F	Rural Route Numb	oer, City or To	wn, State, Zi	
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			for State Registrar	State of	Marylan		artmen rtificat				ental Hy	giene	2009	032	74
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	Funeral Director			Sex 1 2 M 2 □ F	Age (In yrs. 81	last birthday) Yrs.	If Under Months	Days	Hours	Min.	8. Date of Bir (Month, Da Iov. 15	rth ay, Year) 5,1927 9. Birthplace (State or Foreign Country) Maine			
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altimore,	Pages ment of ant: If its ury or o		1 ☑ Burial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Spec		ate Ga	te of Cemeter	Heave ry	n		Jan. 2 2009		Silv	er Spr	ing, MD	
Ball	permit. Pages Department of Important: If it any Injury or o		21. Signature of Furneral Service Livensee 22. Name and Address of Facility DeVol Funeral Ho 2222 Wisconsin Ave., N.W. Washing											, D.C. 2	0007
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State of Maryland / Department of Health and Mental Hygiene 03275 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 18, 2009 9:36 P. M R. Glasner January Deborah /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Holy Cross Hospital Silver Spring If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye Aug. 20, Birthplace (State or Foreign
Country) 5. Social Security Number 6 Sex Year) 1921 **Funeral** Months 1 □ M 2 👿 F 87 Hungary Director 559-72**-**7628 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County show ed other than "natural", or Items 23a or 28a-f show 14 Yes 2 □ No Director Silver Spring Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20901 U. S. A. 405 Neal Avenue by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ∐Yes 2 🔀 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. White Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 Years Pages 1 and 2 should be filed vent of Health and Mental Hygint; If Item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be of Health and Menta f Item 27 is marked or other traumatic ever Johanna Zilberstein David Deutsch 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 405 Neal Avenue, Silver Spring, Maryland David Glasner - Son injury or other 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If It any injury or concept to the concep 1 Burial 2 Cremation 3 N Removal from State San Hedria Cemetery 1/20/2009 Jerusalem, Israel 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility
Danzansky-Goldberg Memorial Chapels, Inc. Donald (1170 Rockville Pike, Rockville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute Cholecystitis **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Septic Shock Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed Acute Renal Failure burial-tran Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical Respiratory Failure IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 X No Month 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown signed by 1 be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate 1 □Yes 2X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Anpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2X No Certification: To After this funeral c 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director; After it completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number January 19, 2009 D65953 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, Maryland 20910 Adaku Chimtua Onukogu 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** JANUARY 21, 2009 1:06 A M DALE LEE GRIMES /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CHESTER RIVER HOSPITAL CENTER CHESTERTOWN KENT 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Funeral Months Days 1**x** M 2□ F Hours 49 Director MARYLAND 217-74-3299 JULY 1,1959 Usual Residence of Decedent ss 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 XNo Director MARYLAND QUEEN ANNE'S STEVENSVILLE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21666 UNITED STATES 200 DUKE STREET Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 2 X No Specify: WHITE 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 WATERMAN SEAFOOD 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SHELBY JEAN GERNERTT GEORGE MERLE GRIMES ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 DUKE STREET, STEVENSVILLE, MARYLAND GEORGE MERLE GRIMES/FATHER 21666 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Itel
any Injury or ott 1 ☐ Burial 2 TCremation 3 ☐ Removal from State CHESAPEAKE CREMATION JANUARY 2009 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE, MARYLAND 21. Signature of Funeral Service 22. Name and Address of Facility
FUNERAL HOME, PA,
MARYLAND 21619 FELLOWS HELEENBEIN & NEWNAM, TOO SHAMROCK ROAD, CHESTER, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HOURS MYOCARDIAL INFARCTION /Medical CORONARY ARTERY DISEASE YEARS Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner YEARS **HYPERTENSION** physician and the burial-trans Due to (or as a consequence of): nding physician **ATHEROSCLEROSIS** YEARS Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the 1 Tyes 2 TNo 9 ☐ Unknown ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by been signe should be PERIPHERAL VASCULAR DISEASE 1 ☐ Yes 2 ☐ No 🔏 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an cate has page 2 s autopsy perform 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ▼ No Certification: To 1X Inpatient 2 ER/Outpatient 3 DOA ij 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 🕅 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

Division or Vital Records, certificate After the or Attending thin 24 hours after death.

the Funeral Director: A mpletely filled in by the fu death. within 24 h To the Fu

death certificate be executed

Box 68760.

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Maryland 21215-0036

Saltimore,

State Registrar

M. D. CROWLEY, MD 31. Date filed (Month, Day, Year)

(Check only one)

29b. Signature and title of certifi

610 DUTCHMANS LANE, EASTON, MARYLAND

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D25933

29d. Date signed (Month, Day, Year)

01/22/2009

21601

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death January 19. 2009 Gary Lee Green 7:58 PM 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year I If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, July 2, Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Months Days Hours Min 1√X M 2 □ F 73 578-44-2132 July 1935 Washington D.C. Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 1 □ Yes 2 No Riva Maryland | Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 214 Orchard Road 21140 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give' Ye ar or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2√No Specify White 3 ☐ Widowed ★ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Plumber Plumbing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wheeler Green Doris Cox 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David L. Green / Son 54 Rineer Drive Quarryville, Pennsylvania 17566 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) YS Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lakemont Mem. Gardens: 1/23/2009 Davidsonville, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. Michel of Stor 147 Duke of Gloucester St. Annapolis, MD 21401 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Physician /Medical Examiner

Physician

/Medical

Examiner

10a State

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Funeral

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Ilmportant: If them 27 is marked other than "natural", or items 23a or 28a-f show any lijury or other traumatic event, the Medical Expringer must he marked once.

Baltimore, Maryland 21215-0036

physician and s the burial-tran signed by the a certificate has brieflector, page 2 s funeral director, After this ours after death.
neral Director: Af
filled in by the fur

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

shock, or heart failure. List only o	ne cause on such line.	, 5.	. ,	Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a	Amythuia		Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b			
that initiated events resulting in death) Last	Due to (or as a consequence of):			
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		ictopic pregnancy hther (specify)	23	3d. Date of delivery Month Day Year
Part II. Other significant conditions co	ntributing to death but not resulting in the unde	erlying cause given in Part I.		e contribute to the cause of death? No 3 ☐ Probably ♣️ Unknow
			24a. Was an autopsy performed?	24b. Were autopsy findings availabl prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical		26. Place of Deatl	(Check only one)	
examiner?	lospital: 1 ☐ Inpatient 2☐ ER/Outpatient	3 DOA Other: 4 Nursing Ho	me 5 Residence 6	Other (Specify)
27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury		28d. Describe how injury	
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street building, etc. (Specify)	, factory, office	28f. Location (Street and City or Town, State)	Number or Rural Route Number,
1 Yes 2 No 27. Manner of Death Natural 5 Pending investigation 3 Suicide 4 Homicide Certifying Phy 29a. Certifier Check only one) 2 Medical Examination 29b. Signature and title of certifier	sician: To the best of my knowledge, death of the basis of examination and/or investand manner stated.	ccurred at the time, date and place, stigation, in my opinion, death occur	and due to the cause(s) red at the time, date and	and manner as stated. place, and due to the cause(s)
29h Signature and title of certifier		29c. License number	29d Date	signed (Month, Day, Year)

Annapolis, md

29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

within 24 hours a

completely

nopra Date filed (Month, Day, Year)

title of certifier

2001

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29b. Signature

State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** EDNA HINTON F. 2009 8:40 P /Medical January 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SOUTHERN MARYLAND HOSPITAL CENTER CLINTON PRINCE GEORGE'S If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, **Funeral** Months Davs Hours 1 □ M 2 😾 F Min. Director 578-12-6026 93 9/15/1915 Washington, DC Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at Director tyE Yes 2 □ No DC Washington 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number ò Pages 1 and 2 should be filed within 72 hours after death with 238 20020 3524 Highwood Drive S.E. United States Funeral or Items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 2 Specify: Black 3 Nidowed 4 Divorced 'natural'. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Clerk of Health and Mental Hygie item 27 is marked other Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ unk Edward Pratt Beatrice 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hardrian Ln. Fort Washington, Maryland 20744 Edward C. Pratt / Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of I Important: If ite any injury or of t Вurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/22/2009 Brentwood, Maryland Fort Lincoln 22. Name and Address of Facility Pope Funeral Homes, P.A. 21. Signature of Funeral Service Licensie 23a. Parl F. Enter the disease, or complication, that caused the death, shock, or learn failur. List only one cause of each light. 5538 Marlboro Pike Forestville, Maryland 20747 Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betyfeen Onset/and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or/as a consequence of attending physician for use as the buria Physician/Medical yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23c If 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23d. Date of delivery 3 Ectonic pregnancy Month Year Day Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Director: A 1 □Yes 2 □No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 29a, Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of cartifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) prite 101 700 OCL 32. Registrar's Signat State Registrar

DHMH 17 Rev 1/2001

Box 68760.

P.O.

Division of Vital Records,

State of Maryland / Department of Health and Mental Hygiene 1- State 1-28-09 Registrar Amend#'s4a.19b.PerPhys.&Fam.PCCcr Certificate of Death 03279 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 16, 4:05 a M 2009 Norman Sinclair Henderson January /Medical Reacility Name (If not institution, give street and number)
Orestville Health
Millenium Nursing & Rehab. 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges & Rehab. Center Forestville Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Months Days Hours 13K] M 2 ∏ F 209-36-7163 61 16,1947 Phila. Director Dec. Pa. Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City. Town or Location 10a, State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at Maryland Prince Georges Forestville 1 XYes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7420 Marlboro Pike 20747 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □XYes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married "natural", or Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Medical Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4or 5+) the 1 4 Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked c permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked any injury or other traumatic ew Purvis S. Henderson Helen Dickens 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jayne H. Brown / Sister 1939 Fawn Dr. Larerock, Pa. 19038 Laverock, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Jan.17,2009 Alexandria, Va. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses ² Name and Address of Facility Alexander S. Pope 5538 Mariboro Pike/ Forestville, Md. 20747 Jange 401005 Part 1. En in the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a, Part Immediate Cause (Final disease or condition resulting in death) Stroke Recurrent **Physician** /Medical Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-transit Diabetes Mellitus and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical as IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown certificate has been signed by rector, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Stroke 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 1∐ Yes 2 XNo or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4₺ Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No 2 this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. 28d. Describe how injury occurred Certification: Injury at Work? After (Month, Day Year) Injury 1 Natural 5 Pending To the Hospital or Attention.
within 24 hours after death.
To the Funeral Director; Aff investigation 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🔀 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D51520 January 16, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bahram Pishdad, M.D. 1328 Southern Ave. S.E. Washington, D.C. 20032 31. Date filed (Month, Day Year) 32. Registrar's Signature State JAN 2 2 2009 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No.2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 3:00 рм 18 2009 Jack Α. Hillman January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Montgomery Bethesda Suburban Hospital If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 ☒ M 2 ☐ F December 7, 1926 District of Columbia Director 577-36-8186 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 🖾 No Maryland Chevy Chase Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ò items 23a 20815 3105 Woodhollow Drive Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" ~ any injury or other traumatic even. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian 11. Marital Status Black, White, etc 1 ☐ Never Married 2 🖾 Married 1 ☐ Yes 2 ☒ No Specify If Yes, Give Year or Dates þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Law Office Attorney 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ Abraham Louis Hillman Hinda Schwartz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lillian Hillman - Wife 3105 Woodhollow Drive, Chevy Chase, Maryland 20815 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King David Memorial Gardens 01/21/2009 Falls Church, Virginia 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final , Physician Aspiration Pneumonia 2 days disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 2 days Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) certificate be executed physician and s the burial-trans 2 days Multisystem Organ Failure resulting in death) Last Due to (or as a consequence of): 68760 Physician/Medical Years Chronic Obstructive Pulmonary Disease the attending p use as Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23h. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Day Vear P.0. cate has been signed by the page 2 should be detached 1 ☐Yes 2 ☐ No. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐Yes 2 ☐No 24a. Was an After this certificate has autopsy 1 ☐ Yes 2 ☒ No Vital funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🖾 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To ō 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 5 Pending investigation Division 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title/o 29c. License number 18 Old Georgetown R 30. Name and address on who completed cause of death (Item 23a) (Type, Print) Subserba Hospital 31. Date filed (Month, Day, Year) 2. Registrar's Signature State 22 Registrar

60/21

HILLMAN

Ack

		,	for State Registrar	State of Mar		artment of F rtificate of			giene Reg. No. 2		03281
	Physici		1. Decedent's Name (First, Middle, La. Doshia S.	Harris				2. Date of De Month Januar	Day	Year 2009	3. Time of Death 4:05 A
	/Medio Examir		4a. Facility Name (If not institution, giver Larkin Chase Number 1	street and number)		4b. City, Town, o			4c. Co	ounty of Death	
	Funeral Director		5. Social Security Number 6. S 578–46–1971 1	,	In yrs. last birthday)	Bowie If Under 1 Year Months Days		n. (Month, Da	rth ay, Year)	Cou	place (State or Foreign ntry)
	D		Usual Residence of Decedent					Jan 9,	1934		ington, DC
	farylar show	ō	10a. State 10b. County Maryland Prince	George's	Oc. City, Town or Lo Bowie	cation					10d. Inside City Limits M☐Yes 2☐No
	r 28a-	irect	10e. Street and Number	300280		10f. Zip Code			10g. Citizer	n of What Cou	ntry?
	th with	ralD	15608 Everglade	Lane #D103		20716			Unite	ed Stat	es
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any figury or other traumatic event, the Medical Evantriar must be notified at ance.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates:	I .	Was Decedent of H If Yes, specify Cuba 1 □Yes 2★No	Hispanic Origin? an, Mexican, Pue Specify:	(Specify Ye's or No erto Rican, etc.)		Race - Ameri Black, White, pecify:	
5-0	72 ho 'natur	eted	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	ation during most of w	vorking	16b. Kind	of Business/In	dustry
21215-0036	d within giene. er than '	Completed	Sementary/Secondary (0-12)	College (1-4or 5+)		od Servic			Go	overnme	nt
Maryland	be file	Be	17. Father's Name (First, Middle, Last)					ame (First, Middle		rname)	
ıry.	should nd Mei marke imatic	٩	John H. Salley 19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street		Hendric		own State Zin	n Code)
	aith ar aith ar 27 is er trau		Robert C. Harris	**	- 1	Everglad					*
Baltimore,	Pages 1 aent of He nt: If item y or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	inemoval from State	20b. Place of Dispo		i	Date		tion - City or To	
Saltiı	permit. F Departm Importar any injur		21. Signature of Funeral Service Licer		Lee's Cr	2. Name and Addre		26 , 200 Stewart			
	20 E # 9		MINOSI	n, DC							
A.	Physician /Medical		23a. Part Enter the disease, or com sh has beart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line. Dement:	ia	er the mode of dyli	ng, such as card	iac or respiratory a	arrest,		Approximate Interval Between Onset and Death
	Examiner			Due to (or as a c	onsequence of):						
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events	Due to (or as a co	onsequence of):						
68760,	ificate be executed g physiclan and as the burial-transit	edical Exa	resulting in death) Last	Due to (or as a co	onsequence of):						
89 J			IF FEMALE:	32.77							
.O. Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ X o 9 □ Unknown	23c. If yes, outcome of particle of the second of the sec	Fetal death 3	☐ Ectopic pregnand ☐ Other <i>(specify)</i> _	y		230	d. Date of deliv Month	ery Day Year
Records, P.	uires that n signed t Id be deta	þ	Part II. Other significant conditions of Hypertension	ontributing to death but n	not resulting in the u	nderlying cause giv	en in Part I.				he cause of death?
000	e law requir has been s le 2 should	Completed	Cerebrovascular	Accident				24a. Was		24b. Were auto	ppsy findings available
Ä	: The I	Som				·		– auto perfo 1 □ Yes	psy ormed? 2 ANo	death? 1 □ Yes	mpletion of cause of 2 □ No
of Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Oth		eath (Check only o	one)		
	Phys er this eral dir	۲: T	1 Yes 2 XNo 27. Manner of Death	28a. Date of Injury	2 ER/Outpatier		4 La-Nursing	Home 5 ☐ Resi			fy)
ion	Attending For the death. ector: After by the funerant	atior	1 ⚠ Natural 5 Pending 2 Accident investigation	(Month, Day, Yo	<i>(ear)</i> Injury		kí? Yes 2 □ No		,,		
Division	i gite	Certification: To	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (- At home, farm, str (Specify)	eet, factory, office		28f. Location (City or To		lumber or Run	al Route Number,
	d the	Medical	29a. Certifier (Check only one) 1 ☑ Certifying Pr 2 ☐ Medical Exam	nysician: To the best of n niner: On the basis of ex and manner stated	camination and/or in	h occurred at the tivestigation, in my o	me, date and pla opinion, death oc	ace, and due to the ccurred at the time,	cause(s) ar date and pl	nd manner as a ace, and due t	stated. o the cause(s)
	To the It within 24	Me	29b. Signature and title of certifier	7	N	29c. Licens	se number		29d. Date s	signed (Month,	Day, Year)
			· yr	A	<u> </u>	D452	217		Janu	ary 19	, 2009
R	2		30. Name and address of person who Ade Isaac Ajayi,	-	h (Item 23a) (Type, Greenbel		118 Coll	ege Park	. MD 2	20740	
	Sta	te	31. Date filed (Month, Day Year)		Signature			0			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-00419 State of Maryland / Department of Health and Mental Hygiene Franklin D Holmes 1- For State Certificate of Death Registrar Decedent's Name (First, Middle Last) 2. Date of Death Physician/ Month Day January 15, 2009 0246 hrs Medical Examiner Franklin D. Holmes, III 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Old Elkneck Road and Foxwood Drive Elkton Cecil B. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 5. Social Security Number 6 Sex Age (In yrs. last birthday) **Funeral** Months Days Hours Min Director 10/17/1987 Maryland 219-17-8740 1X M 2 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show E1kton Maryland Cecil or items 23a or 28a-f shomust be notified at once. rector death with the Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21921 United States 120 Wayside Drive ā Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces White, etc. 1 X Never Married 2 Married 2XX No Yes imore, MD 21215-0036

2. Pages 1 and 2 should be filted within 72 hours after onent of Health and Mental Hygiene. If Yes, Give Year Specify: Yes 2 X No specify: Widowed Divorced White "natural" þ or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) pleted Elementary/Secondary (0-12) College (1-4 or 5+) event, the Medical other than Shipping and Receiving Clerk Manufacturing Com 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Important: If item 27 is marked Be Franklin D. Holmes, Jr. Wyvonne Gooslin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Franklin D Ho Wyvonne Holmes Holmes, Jr. Parents 120 Wayside Drive, Elkton, Maryland 20a: Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Baltimore, crematory or other place) January 1 X Burial 2 Cremation 3 Removal from State New Castle, Delaware Gracelawn Memorial Park 21,2009 Donation 5 Other Specify: f Funeral Service Licensee 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 Approximate Interval ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line Medical a. THERMAL BURNS AND INHALATION OF SMOKE AND SOOT Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical UNPENDED AMENDED Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Live birth Fetal death past 12 months Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Completed Records, neen 24a. Was an autopsy has performed? death? page ✔ Yes 2 Yes ~ 25. Was case referred to medical Be

Hospital or Attending Physician: The law requires that the death certificate be executed of Vital this After Division hours after death.

uneral Director: /

1 Yes 2 ✓ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 2 26.Place of Death (Check only one) examiner? Hospital: 1 Other₄ DOA Nursing Home 5 Residence 6 V Other: Scene Innatient 2 ER/Outpatient 3 1 🗸 Yes 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Jan 15, 2009 Driver auto fixed object collision with 0230 hrs Natural Yes 2 ✔ No Pending subsequent fire 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be or Town, State) Old Elkneck Road and Foxwood Drive, Elkton, MD Suicide (Specify) Roadway determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

30. Name and address of person who completed cause of death (Item 23a)

Russell Alexander MD. Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

32. Registrar's Signature

29d. Date signed (Month, Day, Year)

January 15, 2009

Yes 2 X No

Death

Year

within 24 ho To the Func completely f

Medical

09-00578

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Millard Fillmore H		tt, III - For State	St	ate of	Maryla		epartmei <i>Certificat</i>		Health and Death	Mental	Hygie		n No.	0.0	0 0000
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Medical Examin		Milla	rd	Filmo	ore	Ho11	ett, I	II _			Jar	onth nuary 20			1104 hrs
Pass		4a. Facility Name (i 23 Cecilton			eet and nu	mber)		4b	. City, Town, or L Warwi ck	ocation of D	eath		4c. County of	Death	
Funeral		5. Social Security N	lumber	6. Sex		7. Age (In	yrs. last birtho	day)	If Under 1 Year		_	Date of Birt	(MM/DD/YYYY)		thplace (State or Delaware
Director		221-30-2	2517	1 X M	2 F		62	Yrs.	Months Days	Hours	Min.	09/28	/1946	Cou	untry)
		Usual Residence o	f Decedent			140-	0.4	Location							10d, Inside City Limits
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yland 1-f sho	흱	MD 10e. Street and Nu	Ceo	cil			Warwic		10f. Zip Code			10	g. Citizen of Wh	at Cour	ntry?
re Mar or 28:	Director		cilto	n Man	or Dr	ive			2191	2			USA		
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hears after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status			2. Was Dec	cedent Eve	r in U.S.	13. Was	Decedent of His	panic Origin	? (Specify	Yes or No-			ican Indian, Black,
death r	uneral	1 Never Marri	ed 2 N	1	Armed F Yes	2	No	If Yes	s, specify Cuban,	Mexican, Pi	Jeno Ricai	i, etc.)	ļ		
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5-0036 lled within 7 Hygiene. d other than the Medica	5	17. Father's Name	(First, Middle	e, Last)						8.Mother's I	Name (Firs	t, Middle, N	laiden Surname)	
121. I be fil ental F nrked	Be	Millar				r.	Lia	14-11	Address (Stree				liott	n State	Zin Code)
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my MD and 2 sho lealth and tem 27 is traumati		20a. Method of Dis	position					Disposit	ion (Name of cer	netery,	Dat	e	20c. Location -	City or	Town, State 21919
Baltimore, permit Pages I an Department of He Important: If ite		1 X Burial 2			Removal f	rom State			^{er place)} Veteran	s (01/26	/2009	Bear,	, DF	C.
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Physician		23a. Part I. Enter t failure. List or				caused the	death. Do not	enter the	e mode of dying,	such as care	diac or resp	oiratory arr	est, shock, or he	art	Approximate Interval Between Onset and
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c 68 certif ending use as	sician/Me	past 12 month				nant at tim	e of death 5	=	al death 3 ner (Specify)	Lotopio	rogramoy				
Box 68760, redeath certificate be executed the attending physician and ted for use as the burial - transit	Physi	1 Yes 2			9 Unki							00 - D/d -		aib. sta A	o the course of death?
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S, P.	ed											24a. Was			autopsy findings available
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tal Rec cian: The L certificate P	5											1 Yes	2No1	1 🗸 Y	Yes 2 No
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Division ospital or Attendi hours after death. meral Director: /	Certification:	2 Accident 3 Suicide		vestigation ould not be	28e Pla				et, factory, office	ouilding, etc.	. 28f	. Location or Town,		per or F	Rural Route Number, City
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1 24 T	Medical (29a. Certifier 1 (Check only one)	Certifying Medical Ex	xaminer: C	n the basi:	s of examin	nowledge, dea nation and/or in	ath occur nvestigat	red at the time, dition, in my opinion	ate and place n, death occ	e, and due urred at the	to the cau e time, date	se(s) and manne and place, and	er as sta due to	ated. the cause(s)
To the within 7 To the complex	Med	29b. Signature an		a	nd man <u>ner</u>	stated.	-		29c. Licen						fonth, Day, Year)
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			1 - For State Registrar	State of	Marylan		artmen rtificate					g. No.2 (009	032	284
	Physici /Medic		1. Decedent's Name (First, Middle, Las Alice V. Hauser								2. Date of Death Month January	17, 2		3. Time of I	Death A ^M
	Examin		4a. Facility Name (If not institution, give 1919 Bishoff Road 5. Social Security Number 6. S	3	ber)	last hirthday)	7.	ends	ville	•	8. Date of Birth		rett	lace (State or	r Foreign
	Funeral Director			□ M 2 🛣 F	90	Yrs.	Months	Days	Hours	Min.	July 2,	^{Ye} 1918	Penr	isylvan	ia
	e Maryland 8a-f show tiffied at	ctor	MD 10a. State 10b. County Garrett			y, Town or Lo iendsv								0d. Inside City 1 ☐ Yes	
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21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	eted by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced 15. Decedent's Ec (Specify only highest gra	12. Was Deced Armed Ford 1 Yes 2 if Yes, Give Year or Dat ucation de completed)	ces? 2 🔼 No	16a. Dece	Was Deced If Yes, spec 1 ☐ Yes :: dent's Usua kind of wor DO NOT us	2 No	Specify:		cify Yes or No- Rican, etc.)	Spec	tace - Americ Black, White, cify: whit Business/In	etc.	
7121	within jiene. r than "the Med	Completed	Elementary/Secondary (0-12)	College (1-	4or 5+)		во мот us maker	se retired,)			Own	Home		
Maryland 2	ould be filed Mental Hyg arked other atic event,	To Be C	17. Father's Name (First, Middle, Last) George Bond								(First, Middle, N Veach				
Baltimore, Mary	ages 1 and 2 sho ent of Health and i tt: if item 27 is me y or other traums		Julia E. Rush/dau 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifications)	ighter Removal from S	tate	179 Place of Disponentery, cre-	Klotz osition (Nan matory or o	Road ne of other place	d, Fr	iend:	sville, ate	MD 2	21531 n - City or To	own, State	
Baltir	permit. P Departme Importan any injur		21. Signature of Funeral Service Licer		سعع	N 2	2. Name an ewman	d Addres	s of Facilit eral	y Home:	s, P.A.,	, P.O.	Box 2		
3760,	Physician /Medical Examiner wisician and per period in the privilent in th	ical Examiner	23a. Part1. Enter (ha) disease, or com shock, or hear failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Athe Due to (of b. Hype Country to (of country)		eroti Juence of): Sion Juence of).					ir dise			Approximate Interval Betwoonset and D	veen
.O. Box 68	The law requires that the death certifica ate has been signed by the attending phoage 2 should be detached for use as the	Physician/Med	iF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		rth 2 ☐ Feta int at time of c	al death 3	⊒Ectopic pr ⊒ Other (sp						Date of delive		'ear
rds, P	quires that n signed b uid be deta		Part II. Other significant conditions of Dementia, A3	_		_	nderlying c	ause give	en in Part I.		23e. Did tob			he cause of de pably 4 ∐U	
al Reco	has e 2	Completed by									24a. Was ar autops perforr 1 Yes 2	у	prior to co death?	opsy findings a mpletion of ca 2□ No	
Division or Vital Records, P.O. Box	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, pag	Certification: To Be	25. Was case referred to medical examiner? 1	28a. Date o (Month	patient 2 f Injury n, Day Year) of injury - At h g, etc. (Speci	28b. Time of Injury	of 2	8c. Injun Work 1 □ `	er: 4 🗆 Nu	nrsing Hon	(Check only only only only only only only only	ence 6 🗆 Cow injury occurreet and Nui	curred		ber,
_	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical Ce	29a. Certifier 1 ★ Certifying Ph (Check only one) 2 Medicai Exar	ysician: To the I	sis of examina	owledge, deat ation and/or in	th occurred ovestigation	at the tin	ne, date ar pinion, dea	nd place, a	and due to the ca	ause(s) and ate and plac	manner as s ce, and due t	tated. o the cause(s))
	To the within 2 To the complet	Me	29b. Signature and itle of certifier	AK	Itte	2>1	1	D30					ned (Month,		
_		3	30. Name and address of person who Donald R. Ri	chter,	M.D.	1533		rial	l Dr	ive	0aklan	d, MI	0 215	50	
	Sta Regist		31. Date filed (Month Day Year)	2009 32. Re	gistrar's Sign	ature A. A	barke	1							

DRIMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Irene Musgrove Harr 19, 2009 10:15 A^{M} January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 1 M 2 X X 042-20-7906 81 1927 Director Connecticut Usual Residence of Decedent رست که Should be filed within 72 hours after death with the Maryland aith and Mental Hygiene.
27 is marked other than "natural" مه المحتمد traumatic event. 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location Maryland Anne Arundel Annapolis Yes 2 ☐ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 12 Silverwood Circle, #6 21403 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼No Race - American Indian. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates White Completed by ¥XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Chief Financial Officer Stock Broker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic evonce. Harold Fine Bessie Galinsky ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeffry Musgrove/son 12 Silverwood Circle, #6 Annapolis, Maryland 21403 Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Arlington Nat. Cemetery 1/30/2009 Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Euneral Senice Licensee 147 Duke of Gloucester St., Annapolis, MD 1000 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory in st, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Intracerebral Hemmorrhage Physician disease or condition resulting in death) 48 hours /Medical Due to (or as a consequence of): Examiner 48 hours Cerebrovascular Accident Seque, trally fiet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ne Physician: The law requires that the death certificate be executed Exami and burial-trar Due to (or as a consequence of): nding physician ause as the burial-P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy ö Month Day Year 5 Other (specify) 1 □Yes 2XXXIo ned by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by sign 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has perform 1 ☐ Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) di 1XXYes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this After this funeral of 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred ospital or Attending Phours after death.
Ineral Director; After I y filled in by the funers Subject fell 1 Natural 5 Pending investigation 1∐Yes 2XXXNo 1/17/2009 9:00 A^M 2XXAccident from standing position 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3023 Arundel on Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Assisted Living Facility the Bay Rd. Annapolis, MD within 24 hours a

To the Funeral C

completely filled Hospital **ExCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated To the I within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of ceptifie 29c. License number Jan. 19, 2009 D64089 ai 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2001 Medical Parkway Mark Sanchez, MD Annapolis, Maryland

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JAN 2 1 2009

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 19 January John Thomas Hall /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's St. Mary's Hospital Leonardtown If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) 6/22/1925 **Funeral** Days Hours 1 ☑ M 2 ☐ F 83 577-28-8421 Washington, DC Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 TYes 2 TXNo Director Anne Arundel Maryland Edgewater 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 401 Beach Drive 21037 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Retired 1 ∰Yes 2 □ No If Yes, Give Year or Dates: 1962 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural"; or iten any Injury or other traumatic event, its Medical Examination. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No þ Specify: 3 Midowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 7th College (1-4or 5+) Home Builder Construction 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be James Ernest Hall Annie Agnes Dean ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 401 Beach Drive, B. Kay Gioffre/ Daughter Edgewater, MD 21037 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery 1/28/2009 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature Juneral Service Licenses 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1 Inter the disease, or comblications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on sach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Martes **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of) 68760, The law requires that the death certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 \(\subseteq \text{Live birth} \) 2 \(\subseteq \text{Fetal death} \) 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No Ö the 9 Unknown detached 9 Unknown signed by σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 4 Unknown 1 🗌 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed certificate Vital 1 ☐ Yes or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🔲 Inpatient 2 KER/Outpatient 3 ☐ DOA Medical Certification: To 1 Yes this of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director; After Division 1 Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospita! 15 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifiei completely and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number WD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 14 fatthew

31. Date filed (Month, Day, Year)

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Registrar

JAN 21

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Amended Item 10b per F.D. 01/20/2009 Carroll County, wj1
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2009 Elmer Jacob Hahn М January 18, 4:45a /Medical 4b. City, Town, or Location of Death
Westminster 4c. County of Death
Carroll 4a. Facility Name (If not institution, give street and number) Examiner Carroll Hospice Dove House 8. Date of Birth Sep 5, 1914 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 □ F 94 Director 218-09-7685 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County Carrol1 r 28a-f show notified at 1 ☐ Yes 2 No Baltimore Directo Maryland Upperco 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 1455 Emory Church Road 21155 permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or: a mortant if item 27 is marked other than "natural", or items 23a or: any Injury or other traumatic event, the Medical Examiner must be none. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: WWI. 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: white þ WWTT 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steel Worker Steel Company 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be Charles D. Hahn Martha Fringer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Elmer John Hahn, son 115 Liberty Street, Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Trinity Lutheran Cem 1/23/2009 Taneytown, MD 22. Name and Address of Facility Myers-Durboraw Funeral Home 21. Signature of Funeral Service Licensee K. 136 E Baltimore St, Taneytown, MD 21787 rochus 23a. Part) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsa and Death Immediate Cause (Final disease or condition resulting in death) noumonia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usaase It rjury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-tran Due to (or as a consequence of): Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospice Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year 1 Natural 5 ☐ Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🗹 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Physician /Medical Examiner The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, attending properties for use as been signed by the should be detached ate has bage 2 s To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. D

death with the Maryland

Saltimore, Maryland 21215-0036

show

WJL 5+IVA 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State Registrar

State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death - Month **Physician** 20 2009 Marjorie Holbrook Danuar /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner VICOMICO TENINSYUD IONA 8. Date of Birth (Month, Day, Year) If Upder 24 Hrs. If Under 1 Year 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 □ M 2 1 F Hours Min. 83 Maryland 1925 Director 218-20-8583 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 € No Director MD Somerset Princess Anne 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examination of page. USA 21853 13178 McIntyre Road Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □Yes 2X No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify: Black ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Dulaney - Fruitland, MD 12th Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rufus Paul Holbrook Nora Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3129 Warder Street, NW - Washington, DC 20010 Mitchell Holbrook/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Nation 2 In Cremation 3 In Removal from State Trinity UM Comm. Wor. Ct Jan. 24, 2009 Princess Anne, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Şigry turi of Funeral Service License Salisbury, MD 21801 Jolley Memorial Chapel, P.A. - 1213 Jersey Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a conse mence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director. Dags 2 should be detected. Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 🖳 Únknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an 1 □Yes 2 17100 1 ☐Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Propatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ✓ No Certification: To 27. Manner eath 1 Lath tural 2 ☐ Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation Injury 1 □Yes 2 □No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner states 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 1/20/08 30. Name and addless of person who completed cause of death (Item 23a) (Type, Print) arroll St. Salisbury, md. 21801 ouglas W 32. Registrar's Signature State 31. Date filed (Month, Day, Registrar

09-00484 Brookes Harmon

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 03290

		For State	Certifi	cate of Death			Reg. N	lo.	
Physician edical Examine	1.	Decedent's Name (First, Middle,Last)	Edward	HARN			Date of Death Month Da January 17, 2	2009	3. Time of Death 0044 hrs
Par		a. Facility Name (if not institution, give str	eet and number)		own, or Location	of Death		4c. County of Do Wicomico	eath
		Peninsula Regional Medical (Salish		lor 24Hre IS	R Date of Birth/M		. Birthplace (State or
Funeral		Social Security Number 6. Sex	7. Age (In yrs. last t	oirthday) If Unde Month:			4-01	I F C	country) MARYAND
Director	2	17-96-0725 1XM	2 F 27	Yrs.			4-01	-81	Source Hand
Variation in the	U	sual Residence of Decedent		wn or Location					10d. Inside City Limits
w any	1	Da. State 10b. County		lisbury					1 Yes 2 No
daryland 28a-f show d at once.	<u> </u>	PARYLAND Wicomi	CU JA	10f. Zip	Code		10g.	Citizen of What	Country?
Mary r 28a-	Director	0e. Street and Number	O DRIVE		1801			USA	
			2. Was Decedent Ever in U.S.	13 Was Decede	nt of Hispanic O	rigin? (Spec	cify Yes or No-	14. Race - A White, e	American Indian, Black,
items	Funeral	1 Never Married 2 Married	Armed Forces? Yes 2 No	If Yes, speci	y Cuban, Mexica	an, Puerto Ri	can, etc.)	· .	
er de		3 Widowed 4 Divorced If	Yes, Give Year		No specif			Specify:	
urs af tural	함	15. Decedent's Education (Specify only	highest grade completed) 16	6a. Decedent's Usual during most of wo	Occupation (Giverling life, DO NO	e kind of wor OT use retired		6b. Kind of Busin	ness/industry
5-0036 led within 72 hours et Hygiene. other than "natur:	ompleted	Elementary/Secondary (0-12)	College (1-4 or 5+)	Labo				NONE	-
036 vithin one.	립		04	LADO		ner's Name (I	First, Middle, Mai		
5-0 iled v Hygin I othe	ပ	17. Father's Name (First, Middle, Last)	INSON III		(Se	Scque	INE	HARM	ON
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than it event, the Medics	o Be		- D-(-4.)	19b. Mailing Addres	S (Street and N	lumber or Ru	ral Route Numbe	er, City or Town,	State, Zip Code)
MD 2 d 2 shoul lth and N n 27 is n		19a. Informant's Name/Relationship (Type) CQUE! NE FIARM	non-1 other	1207 FIR	mingo	DR.	Salisbu	ery. Md	্রা৪০
e, M	1	20a. Method of Disposition	20b. Pla	ace of Disposition (Na ematory or other place	ille of certiquery,	1		20c. L‡cation - C	
imore, MD 2121 Pages I and 2 should be finent of Health and Mental inner of Health and Mental is marked on other traumatic event,	-1	1 Burial 2 Cremation 3	Removal from State			1-2	24-09	SAlis	abuen Md
Baltimore, permit. Pages I a pepartment of He important: If ite	-	4 Donation 5 Other Specify: 21. Signature of Funeral Service License		22. Name an	Address of Fac	cility		2011	ela i ml
Balti permit. Departn Import	1	Glady B. Ste	wart	STEWE	el tun	ERA	HOME 8	2 WEEL	t Approximate Interval
Physician		23a. Part I. Enter the disease, or complice failure. St only one cause on each	ations that caused the death. En line.	o not enter the mode	of dying, such a	is caldiac of	respiratory arres	i, shook or mos.	Between Onset and Death
'Medical aminer	-	Immediate Cause (Final disease a. N	Iultiple Injuries						
annie.	ļ	or condition resulting in death)	ue to (or as a consequence of):						
	-	Sequentially list conditions, if any, leading to immediate	ue to (or as a consequence of):						
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	ue to (or as a consequence of)						
ed	Exa	events resulting in death) Last d.	be to to as a consequence of	·					
68760, certificate be executed nding physician and ise as the burial - transit	ख	UNPENDED	AMENDED						
60, ate be	Medical	IF FEMALE:	23c. If yes, outcome of pregn.	ancy				23d. Date of o	delivery Day Year
587 ertifica ling pl		23b. Was decedent pregnant in the past 12 months?	1 Live birth Pregnant at time of dea	2 Fetal dea		topic pregna	ncy	WOITH	bay rou
Box 687 e death certific the attending I	sician/	1 Yes 2 No 9 Unknown	9 Unknown	other (S	ecity)			Y	
	Phy	Part II. Other significant conditions	contributing to death but not re	sulting in the underly	ng cause given i	n Part I.			bute to the cause of death?
P.C s that gened	Š	_					1		Probably 4 Unknown
ds, equire een si	Completed						24a. Was a autops	sy p	Vere autopsy findings available prior to completion of cause of
COF law r has b	mple						perfor	1146.50	eath? Yes 2 No
Re: The ifficate		25. Was case referred to medical			26.Place of De	eath (Check			
ital sician is cert lirecto	Be	examiner?	ospital: 1 Inpatient 2	ER/Outpatient 3	DOA Other	r ₄ Nursir	_	Residence 6	
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that It and are deadle. In since deadle. In by the funeral director, page 2 should be detactled in by the funeral director, page 2 should be detactled.	. To	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time of Injury	28c. Injury at \	_	28d. Describe h Subject assa	now injury occurr aulted	ed
on on anding auth.	tion	1 Natural 5 Pending 2 Accident Investigation	Jan 17, 2009	0011 hrs	1Yes				Durel Poute Number City
ivisior or Attend after death Director: d in by the	ertification:	2 Accident Investigation 3 Suicide 6 Could not	1 28e. Place of Injury - At ho	ome, farm, street, fact	ory, office buildin	ng, etc.	or Town, S	street and Numb tate) rive, Salisbury	er or Rural Route Number, City
Division of Vospital or Attending Phy I hours after death. unerall Director: After the I heart of the I hours after the I heart of the I hea	Certi	4 - Homicide determined	1-1-17 / / 1100100110						
Hos 24 h Fun tely		29a. Certifier Certifying Physici	an: To the best of my knowledge: On the basis of examination a	ge, death occurred at nd/or investigation. ir	the time, date ar my opinion, dea	nd place, and ath occurred	a due to the caus at the time, date	and place, and c	due to the cause(s)
To the Hos within 24 h	Medical		and manner stated.		29c. License nur			29d. Date sign	ned (Month, Day, Year)
	Σ	29b. Signature and title of certifier			O.C.M.E			January 17	7, 2009
				233)					
7 MW OCME		30. Name and address of person who Mary G. Ripple MD. De	completed cause of death (item puty Chief_Medical Exai	miner 111 Pe	nn Street, Ba	altimore, l	MD 21201		E .
/ -	t of		32 Registrar's Signatu		,				
Pagir	tate	124 19 7 7 7 111	19 Cleans	1. 19					

Please Type or Print in Black Indelible 17k., Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jannuary ™29 2009 **Physician** 3:38 A M Richard Crane Harmison /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Aberdeen Harford 1607 Carsins Run Road If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 1 X M 2 ☐ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months W.VA 213-54-2129 57 Director Sept 24,1951 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Show iral", or Items 23a or 28a-f show Examiner must be notifled at 1 Yes 2 No Maryland Harford Aberdeen Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21001 USA 1607 Carsins Run Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White Specify. 2 er than "natural", c 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) is marked other than Automotive 12 0 Auto assembler permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If Item 27 Is marked other trauments. injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown ဥ Edith Harmison 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21001 1607 Carsins Run Road, Aberdeen, MD Rhonda Harmison (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State W.Chester, PA 1/31/2009 RA Ferris & Co. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Tarring-Cargo Funeral Home,
333 S. Parke St, Aberdeen, 21. Signature P.A. MD 2100 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Lance /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed burial-trar Due to (or as a consequence of) physician a P.O. Box 68760. Physician/Medical as attending IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) the detached 9☐ Unknown 9 Unknown ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 SYes 2 No 3 Probably 4 Unknown page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an has autopsy performed? Yes 2 No certificate Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No P this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death.

To the Funeral Director: completely filled in by the f 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ò To the Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 0177/7

Registrar

State

MILHARL

31. Date filed (Month, Day,

Year)

DHMH 17 Rev 1/2001

4940 FAFERY AVE BALTIMINE MA ZIZZY

cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

THOUML

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 0935 M Acicson Menth GAN 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) 13201 Iris Court (CHH ALF) Bowie Prince George's If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Feb. 25 Social Security Number 6. Sex Birthplace (State or Foreign Country) Hours Months Days Min 1 □ M 2 □ 84 yrs. 096-14-5086 Feb. New York Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No New York New York 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 232-06 121st Avenue 11411 USA 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. African 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify: American 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Government 12 Labor Relations Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carter **Emma** Hines Edward 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11084 Scotts Landing Road Laurel, MD 20723 Carol Nash Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Ferncliff Cemetery 1 - 26 - 094 Donation 5 Other (Specify) Hartsdale, New York 21. Signalure of Funeral Service Licensee 22. Name and Address of Facility Jordan Funeral Service, Inc. 4001 Benning Road, NE Washington, DC20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on empline. Approximate Interval Between Onset and Dean Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy Month 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 Yes

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at

filed within 72 hours after Hyglene.

permit. Pages 1 and 2 should be filed of Department of Health and Mental Hygic Important: If Item 27 Is marked other any Injury or other traumatic event. the

Baltimore, Maryland 21215-0036

Director

Funeral

2

Completed

Be

Examine burial-transit attending physician for use as the buria Physician/Medical ed by the signed I Completed director. Be

ဥ

Medical Certification:

The law requires that the death certificate be executed

To the Hospital or Attending Physician:

after death. Director: After this filled in by the funeral

124 hours a

within 2

Division or Vital Records, P.O. Box 68760,

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 9 Unknown

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 | Homicide

(Check only one)

24a. Was an autopsy perform 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 2 No

Other: 4 Nursing Home 5 Residence 6 Dother (Specify) HANDS A 28d. Describe how injury occurred 28c. Injury at Work?

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Descrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and many of stated.

29b. Signature and title of of rtifier

5 Pending investigation

6 Could not be determined

1 Inpatient

(Month, Day Year)

28a. Date of Injury

1 ☐ Yes 2 ☐ No

29th Date signed (Month, Day, Year)

d address of person who completed cause of death (Item 23a) (Type, Print) ENTA MO

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature JAN 2 2 2009

DHMH 17 Rev 1/2001

ORIGINAL

DEFENSE

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 6:19 A KATHERINE DOROTHEA JONES JANUARY 21, 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner ANNE ARUNDEL ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Date of Birth (Month, Day, Year) Months Days Hours 1 □ M 2 🕱 F 80 JUNE 19, 1928 MASSACHUSETTS 022-20-7911 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 ☐ Yes 2 No Directo MARYLAND OUEEN ANNE'S CHESTER 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 407 MERGANSER COURT 21619 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □Yes 2 □ If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Specify: WHITE 1 ☐ Yes 2 🕱 No Specify ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JAMES ISBART HELEN HOOPER ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 407 MERGANSER COURT, CHESTER, MARYLAND 21619 ROBERT ARTHUR JONES 20b. Place of Disposition (Name of cemetery, crematory or other place WOODLAWN MEMORIAL PARK 20c. Location - City or Town, State 20a. Method of Disposition JANUARY 24, 1 MBurial 2 ☐ Cremation 3 ☐ Removal from State 2009 EASTON, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility FELLOWS, HELFENBEIN & SHAMROCK ROAD, MARYLAND 21619 NEWNAM CHESTER 21. Signature of Funeral Sovice Licensee FUNERAL HOME, P.A., 23a. Part 1. Enter the discrete, or complications at caus of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of the death. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Description of Figure that initiated events resulting in death) Last Due to (or as a consequent of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part IJ Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ś 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 TNo 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. "natural", or items 23a or 28a-f show any Injury or other traumatic event, it a Martical Eventre must be notified at angles.

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-tran Ś this After

Be Certification: To

death. within 24 hours after death

To the Funeral Director:
completely filled in by the Hospital

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier as

and manner stated.

5 Pending investigation

6 ☐ Could not be

MD

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

29c. License number

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

29d. Date signed (Month, Day, Year)

2009

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

28a. Date of Injury (Month, Day, Year)

HUNG T. DAVIS. 31. Date filed (Month, Day, Year)

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

4 Homicide

3 ☐ Suicide

29a. Certifier

Medical

State Registrar

2001 MEDICAL PARKWAY, ANNAPOLIS, MARYLAND 21401 32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) January 14, 2009 **Physician** 8:32AM Virginia amh /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Lonaconing Egle Nursing and Rehab Center Allegany If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year)
August 05, 1922 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year 5. Social Security Number 7. Age (In vrs. last birthday, 6. Sex **Funeral** Days Months 1 □ M 2 X F 217-14-4317 86 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f show event, the Madical Exeminer must be notified at 1 XYes 2 ☐ No Director Lonaconing Allegany Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21539 57 Jackson Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: White þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. em 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Health Care Laborer 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rachael Leona Darnley James Albert Ternent ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 22302 Seldom Seen Road, Lonaconing, Maryland, 21539 Melvin Jones, Jr. - Son permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date January 17. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Moscow Mills, Maryland Laurel Hill Cemetery 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License Eichhorn-McKenzie Funeral Home P.A Lonaconing, MD 21539 8 East Main Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 12000 Immediate Cause (Final pan **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed physician and s the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical signed by the attending I IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. Division of Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a Was an To the Hospital or Attending Physician: The law within 24 bouns after death.
To the Funeral Director: After this certificate has i completely filled in by the funeral director, page 2 s autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State Registrar

31. Date filed (Month, Day, Year) JAN 2

Jesus

29b. Signature and title of certifie

srood 32. Registrar's Signature

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29c. License number

21244

29d. Date signed (Month, Day, Year)

physician and s the burial-trans Box 68760, o Division of Vital Records, certificate ha Hospital or Attending Physician: Director:

Reg. No 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) January 20 2009 Physician 4:45 A M Rosalie A. Johnson /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Anne Arundel Severna Park 905 Old County Rd. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth OCOTIN, Bay Year 918 S. County arolina 5. Social Security Number **Funeral** Days Months Hours Min. 1 □ M 2**X** F 90 251-34-8890 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r items 23a or 28a-f show viner must be notified at 1 □Yes 2 No Maryland Anne Arundel Severna Park 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21146 905 Old County Rd. Funeral ould be filed within 72 hours after death on Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1X Never Married 2 ☐ Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Domestic Private Family is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth D. Simmons John E. Johnson ပ Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health a
Important: If Item 27 is
any injury or other trau 905 Old County Rd. Severna Park, Md. 21146 Betty Edwards (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Ocean View Cemetery 1-26-09 Mt. Pleasant, S.C. 4 □ Donation 5 □ Other (Specify) Winname Road Second Security Sons Mortuary, P.A. 21. Signature of Funeral Service Licensee Javy A. Resultable 3 821 West St. Annapolis,
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 821 West St. Annapolis, Md. 21401 Approximate Interval Between Onset and Death Immediate Cause (Final MED PIRATORY 10000 K disease or condition resulting in death) Due to (or as a consequence of): acmonA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine LONGRACIZE Due to (or as a consequence of): Physician/Medical IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 🗷 No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 XNo Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1447494 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. ANNAPOLIS, MY EANGSTON FORE ST 011 1610 Registrar's Signature back Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 03296 For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Gaylord Shearer Knox 12:35 P^M January 19, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Laurel Regional Hospital Laurel Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (Si Country)
October 18, 1923 Thailand Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☑ M 2 ☐ F 85 Director 222-14-0830 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the fivefical Examinant must be notified at Director 1X Yes 2 □ No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20904 USA 3118 Gracefield Road, #317 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc 1 ⊠Yes 2 □ No
If Yes, Give
Year or Dates: 1951–1961 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White δ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry if Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Medicine Radiologist 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Gaylord Knox Lela Emogene Shearer ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Knox Morris / Daughter 6708 Orem Drive, Laurel, MD 20707 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 1/25/2009 Alexandria, Virginia 21. Signature of Funeral Service Liconsec 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Ischemic Cardiomyopathy /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): spital or Attending Physician: The law requires that the death certificate be executed ours after death.

eral Direct car. After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Vear 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ Coronary Artery Disease, New Onset Seizure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 □ Yes 2 🖾 No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 🛛 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 X Natural 5 Pending investigation 1 ☐Yes 2 ☐No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral I 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and D24035 1/20/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3110 Gracefield Road, Silver Spring, MD 20904 Eugenio S. Machado, 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 2 3 2009 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 03297 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death January 20, 2009 **Physician** 8:30A. M Svlvia Krasney /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Silver Spring Renaissance Gardens at Riderwood Village If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov.14,1930 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days 073-22-9535 1 □ M 2 🔀 F 78 yrs. Brooklyn, NY Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County d 2 should be filed within 72 hours after death with the Marylan th and Mental Hyglene.
7 Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20904 3124 Gracefield Road, KC301 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1□Yes 🛣 No White Baltimore, Maryland 21215-0036 Specify. Specify. Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15, Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Title Judge Maryland State Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Clara (unk) Gustave Speigel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Is m any Injury or other traum once. 3124 Gracefield Rd., KC301 Silver Spring, Md. 20904 Sherman Krasney -husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Metropolitan Crematory 1/20/2009 Alexandria, Virginia 4 Donation 5 Other (Specify). 21. Signature of Funeral Service Licente Donald V. Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, Maryland20705 Approximate Interval Between Onset and Death WEEKS 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Cerebrovascular Accident /Medical Due to (or as a consequence of) Examiner Labile Hypertension years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus Insulin Dependent 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes ※ No 24a. Was an page 2 autopsy performed? 1□ Yes 2 XNo certificate Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred e Hospital or Attending P 24 hours after death. e Funeral Director: After t After 1 Certification 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral C i 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and time of D24035 January 20, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E.S. Machado, M.D. 3110 Gracefield Road Silver Spring, Maryland 20904 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JAN 22 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 18, Evelyn Chalmers Krucky January 2009 6:45P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1011 Shore Drive Edgewater Anne Arundel If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 4/11/1919 Birthplace (State or Foreign Country) **Funeral** Hawaii 1 □ M 2 🖾 F 89 Director 215-46-2826 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Wedical Examinar must be notified at Director 1 ☐ Yes 2 🎇 No Maryland Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21037 USA 1011 Shore Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: ģ Specify: Pacific Islander 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Health Care 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Moses Chalmers Florence Muller Department of Health and Mi Important: If Item 27 is mark any Injury or other traumati once. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Toni DeTuncq/Daughter 1011 Shore Drive Edgewater, Maryland 21037 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/20/2009 Kalas Crematory Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD. 21037 23a. Part . Enter the disease, or complice shock, or heart failure. List only one ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Chronic /Medical Due to (or as a consequent) Examiner Sequentially list conditions, Due to (or as a consequence of) any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Year Day 5 Other (specify) ned by the a detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 6astro intestinal Stround No 3 Probably 4 Unknown 1 ☐ Yes Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s r this certificate har autopsy performed 1 □Yes 2 \square No : After this certific funeral director, 25. Was case referred to medical Be darynters recluence 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 2 Accident ithin 24 hours after death. the Funeral Director: A pmpletely filled in by the fu 1 □Yes 2 □ No Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

504

within 2.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State Registrar

(Check only one)

STUGIVE 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

elonicy,

32. Registrar's Signature

29b. Signature and

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 21 Day **Physician** 2009 1845 Donald Eugene Kauffman /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Worcester Atlantic General Hospital Berlin 8. Date of Birth (Month, Day, Year) 8/25/1933 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 1 M 2 □ F **Funeral** Months Days Hours Min 162-26-2515 PA 75 **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Mexical Examiner must be notified at 1 ☐ Yes 2 No Director Berlin MD Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21811 USA 2 Keel Dr. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Dyes 2 No Specify. Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Electrician 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edna Kessler Harry Kauffman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Keel Dr., Berlin, MD 21811 Joanne E. Kauffman / wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cremation Direct Svs. 1/24/09 York, PA 22. Name and Address of Facility Burbage Funeral Home 21. Signatur of Funeral Service Licensee 108 Willian St., Berlin, MD 21811 23a. Part/. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MYOCARDIAL MINUTES IMPARCTION /Medical Due to (or as a consequence of): Examiner Due to (Or es a nonsequence of). YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physiclan and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy 727 0.B in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Record Completed BY-12/155 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has I funeral director, page 2 s autopsy 2 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 MER/Outpatient 3 ☐ DOA 1 Yes 2 □ No Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After t completely filled in by the funera 27. Manner of Death 28b, Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 □Yes 2 □No investigation 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 106241 01-22-69

BA 15+1

Kauffman, Donald

State Registrar 31. Date filed (Month, Day, Year) JAN 23 2009

HOLDNORTH 32 Registrar's Signature Barka

C. Holanth 30. Name and address of person who com sted cause of deth (Item 23a) (Type, Print)

203 SNOW ST SNOW HILL, MD. 21863

State of Maryland / Department of Health and Mental Hygiene 2009 For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Paul Koogle М 29, 2009 1557 January /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a Facility Name (If not institution, give street and number) Examiner Frederick Frederick 6085 Fountain Drive 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) November 29, 1944 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours 1 🔀 M 2 🗆 F 217-42-8878 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h. County ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 1 ☐Yes 2 No Frederick Director Maryland Frederick 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 21702 6085 Fountain Drive United States. death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian, 11. Marital Status Black, White, etc. hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🖾 No Specify. Specify: White ≥ 3 | Widowed 4 | Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natt any Injury or other traumatic event, Ite Illestical (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Police Officer Law Enforcement 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Louis King Paul Frederick Koogle, Sr. ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gerald Koogle / Brother 456 Crosswinds Drive, Charles Town, West Virginia 25414 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition February 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Smithsburg Crematory Smithsburg, Maryland 2, 2009 4 Donation 5 Dother (Specify) 21. Signature of Funera 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 106 East Church Street, Frederick, Maryland 21701 M01433 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Immediate Cause (Final Physician ORDNARY HEARI disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine executed and burial-tran Due to (or as a consequence of) Box 68760. nding physician certificate be Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death
Pregnant at time of death atten 3 Ectopic pregnancy ō Month Year 5 Other (specify) signed by the a □Yes 2 □ No 9 Unknown Ö 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown CHEONIC KIDNLY DISEASE, FIBRILLATION page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an DIABETES MELLITUS has autopsy perform rmed? 2 No certificate 1 🗆 Yes 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending Pwithin 24 hours after death.

To the Funeral Director: After t completely filled in by the funera 5 Pending investigation 1 Natural 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 021936 melson 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 650 THOMAS VOHOUSIN DR FREDERICK ANDREW DONELSON MD マノフロス 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			For State Registrar	State	of Maryland	_	artment of H		id Mental Hy	giene Reg. No2 (009	03301
i i	Physici /Medic		Decedent's Name (First, Middle, JULIA C. LONON	Last)					2. Date of De Month		Year	3. Time of Death
	Examir	er	4a. Facility Name (If not institution, g		,		4b. City, Town, or LARGO				nty of Death	
2.2	Funeral Director		5. Social Security Number 218–14–2062 Usual Residence of Decedent	.Sex 1 DM Ay∏ F	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Birt (Month, Da. 2/25/1	y, Year)	Cour	olace <i>(Stat</i> e or Foreign ort, Maryla
	Maryland -f show fied at	tor	10a. State 10b. County DC			Town or Lo					1	10d. Inside City Limits 1 X Yes 2 □ No
	h with the 3a or 28a st be noti	Funeral Director	10e. Street and Number 2436 Irving Street	et S F		IIIIOIC	10f. Zip Code 2002	n	İ	10g. Citizen o		,
36	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at		11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Dec Armed F	edent Ever in U.S. prces? 211 No ve		Was Decedent of H If Yes, specify Cuba		? (Specify Yes or No- Puerto Rican, etc.)	- 14. R	ace - Americ lack, White,	ean Indian, etc.
21215-0036	thin 72 hour e. an "natural Medical Ex	Completed by	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education			dent's Usual Occup kind of work done o OO NOT use retired		f working	16b. Kind of	Business/Ind	dustry
12 pt	e filed wil al Hygien other th vent, the	Be Con	9th 17. Father's Name (First, Middle, La	ıst)		C1e	rk	18. Mother's	Name (First, Middle,	Priv Maiden Surna		
Maryland	should by and Ments marked	To E	Leo Lorenzo Edel			19b. Mailir	ng Address (Street		Whalen	er. Citv or Tow	n. State. Zic	Code)
ore, Ma	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any figury or other traumatic event, the Medical Examiner must be notified at once.		Linda A. Carroll 20a. Method of Disposition 1 Burial 2 Cremation 3	•	20b. Pla	7728 ce of Dispo		Rd. Hy	vattsville Date	Mary] 20c. Location	Land 2	0785 own, State
Baltimore,	permit. Pa Departmen Important: any injury once.		4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service U	ensee	101085		. Name and Addres	ss of Facility	n.26,2009 Pope Fune ce Forestv	ral Hon	nes, P	A
	Physician /Medical Examiner		23a. Part1. Enter the disease, or co shook, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	a. CARDI Due to	opulmuna Opulmuna (or as a conseque	RY FA				rest,		Approximate Interval Between Onset and Death
8/60,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. HYPER	(or as a conseque	,						
P.O. BOX 6	the death certific / the attending p ched for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	1 ☐Live	tcome pf pregnand birth 2 Fetal c nant at time of dea lown	leath 3□	Ectopic pregnancy Other (specify)	,		1	Date of delive	ery Day Year
	w requires that the d been signed by the should be detached	d by Ph	Part II. Other significant condition	s contributing to d	eath but not result	ing in the ur	nderlying cause give	en in Part I.				he cause of death?
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Division or Vital	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification: To Be	25. Was case referred to medical examiner? 1	28a. Date (Mor		28b. Time of Injury	M 1□	er: 4 🙀 Nursir		dence 6 □O now injury occu	urred	y) al Route Number,
2	To the Hospital or A within 24 hours after To the Funeral Direction properties of the Funeral Direction of the Funeral Di	edical Certif	4 Homicide determine 29a. Certifier (Check only (Check only 2 Medical Expression)	Physician: To the	ing, etc. (Specify) best of my knowl	ledge, death	occurred at the tin	ne, date and p	City or Ton	vn, State) cause(s) and r	manner as si	tated.
	To the H within 24 To the F complete	Medi	29b. Signature and little of certifier		ner stated.		29c. License			29d. Date sign		
	4		30. Name and address of person wh	no completed cau	se of death (Item 2	23a) (Type		1520		1/16/	2009	
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DHMH 17 Rev 1/2001

			For	State of M	aryland		artment of H		d Mental Hy		71119	033	02
			Registrar 1. Decedent's Name (First, Middle,	Last)		Cei	inicate of	Dealli	2. Date of De	Reg. No	o.L 0 0 J	3. Time of De	
8	Physici /Medic		GERMANIA	LIZAR	00				Month	1 1	ay Year 9 / 2009	1931	М
	Examin	er	4a. Facility Name (If not institution,	give street and number)		4b. City, Town, o	r Location of D	eath		c. County of Death		
	Europel		Prince Georges 5. Social Security Number		ge (In yrs. la:	st birthday)	Chever 1	If Under 24 I	Hrs. 8. Date of Bi	rth _	rince Geo	rges lace (State or F	Foreign
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	pu ,		Usual Residence of Decedent			Town or Lo	notion			-1		mingo	Limita
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	the N	Funeral Director	10e. Street and Number	-			10f. Zip Code			10g. C	itizen of What Cour	itry?	
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	ms 2	ner	11. Marital Status	12. Was Decedent	Ever in U.S.	13.	Was Decedent of H	dispanic Origin	(Specify Yes or No uerto Rican, etc.)	0-	14. Race - Americ		
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Medical Exerciting rated by notified at once.	by	1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed Forces ed 1	No		r Yes, specily Cub LXXYes 2 □ No		minican		Black, White, of Specify: Wh	ite	
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aryl	shoul ind M ind M i marl umati	Ĕ	19a. Informant's Name/Relationsh								or Town, State, Zip		
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ore	of He of He fiterr		20a. Method of Disposition 1X Burial 2 ☐ Cremation	2 Demoval from State	COL	ice of Dispo metery, cren	sition (Name of natory or other pla		Date		Location - City or To		
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Baltimore,	permit. Departn Importa any inju		21. Signature of funeral Service L	Seud.			2. Name and Address 2013 Anna		Rendon/Ha Rd. Lanhar		Funeral H D 20706	iome	
		CO ETT	23 . Paul. Enter the dise (se, or o	correcations that cause	d the death.	Do not ent	er the mode of dyi	ng, such as car	diac or respiratory a	arrest,		Approximate Interval Betwe	en
-	Physician		Immediate Cause (Final disease or condition	- FAT	-AL	CAR	DIAC	ARRY.	THMIA.			Onset and Dea	ath
40.	/Medical Examiner		resulting in death)	Due to (or as	a conseque								
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	To the Hospital or Attending Physician: Within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director,	edical C		Physician: To the bes xaminer: On the basis and manner s	of examination								
	To the He within 24 To the Fu	Me	29b. Signature and title of certifier			mp	29c. Licens	se number 403	,	29d. D	ate signed (Month,	Day, Year)	
0	4		29b. Signature and title of certifier 30. Name and address of person y SURES H	tho completed cause of	death (Item 2	23a) (Type	Print) LAVE	# 260,	TAKOMI	A PA	PRIL, M.	D 2091	2_
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Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 10:22A 2009 (CaRDO /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE 5. Social Security Number 6. Sex 7. Age (Center 7. Age (In yrs. last birthday) 55 Yrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 XM 2 ☐ F Months Days Hours Min 3 1953 WASHINGTON, DC Director MARCH 579-70-8005 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Funeral Director MD FREDERICK FREDERICK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1332 TANEY AVENUE # 202 21702 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☎ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2√2 No Specify Completed by Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) COMPUTER ENGINEER PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIE H. LOCKETT RUTH C. CARROLL ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7801 BARLOW RD # 317 LANDOVER, MARYLAND RUTH C. LOCKETT/MOTHER 20785 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 ☐Donation 5 ☐ Other (Specify) RESURRECTION CEMETERY 1/21/2009 CLINTON, MARYLAND 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, ir complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Liu only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of): Completed by Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 ☐ Yes 2 No 1 Yes 2 1 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To

Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the threat director, page 2 should be detached for use as the burn completely filled in by the threat director, page 2 should be detached for use as the burn. P.O. Division of Vital Records,

State

Registrar

Medical

mal

5 ☐ Pending investigation

6 ☐ Could not be

determined

29c. License number DO06 2237

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BALTIMORE

28d. Describe how injury occurred

31. Date filed (Month,

29b. Signature and title of certifier

27. Manner of Death

2 ☐ Accident

3 Suicide

29a, Certifier

4 THomicide

28a. Date of Injury (Month, Day, Year)

and manner stated.

28b. Time of Injury

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State of Maryland / Department of Health and Mental Hygiene \(\begin{align*} \be 03304 1 - State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 7:00 PM Loretta Charlotte Lancaster 2009 January 17, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Renaissance Gardens Nursing Home Prince George's Silver Spring If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 6 Sex 8. Date of Birth **Funeral** Months Days Hours 1 □ M 2 🖾 F Yrs 86 Director South Bend, IN 317-18-0557 August 9, 1922 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant; If Item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, I'm Medical Evaluations to the Italian at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Director Maryland Prince George's Cheverly 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 3202 Tremont Avenue 20785 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Completed by Specify: White 3 Widowed 4 □ Divorced 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done d life. DO NOT use retired) during most of working Elementary/Secondary (0-12) College (1-4or 5+) Contractoring Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charlotte G. Soleta George V. Witucki ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlene Wiseman / Daughter 1202 East Patuxent Drive, La Plata, MD 20646 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages
Department of
Important; If It
any Injury or o 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 1/24/2009 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, Virginia 21. Signature of Fuperal Service Ligenses 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Multiple Sclerosis Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a 1 □Yes 2 🖾 No 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Neuralgia, Cognitive Disfunction 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has briector, page 2 s autopsy 2 🖾 No 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 ☐ Pending investigation ours after death.

eral Director; Aff
filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D24035 1/20/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eugenio S. Machado, 3110 Gracefield Road, Silver Spring, MD 20904 32. Registrar's Signature 31. Date filed (Month, Day State JAN 2 3 2009 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygienen Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year **Physician** Jacqueline Pelletier Lausier 1:35 p^M January 20 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Hours Months Days Min 1 M 2 N F Director 006-20-7716 October 12, 1926 Maine 82 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State show in than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Director Kensington Maryland Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20895 U.S.A 3616 Littledale Road Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. filed within 72 hours after 1 □Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Specify ģ Specify: 3 ☑ Widowed 4 ☐ Divorced Caucasian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "any injury or other traumatic event, Ing Maone. Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Maxim Pelletier Artheline Cyr ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nola Tiernan - Daughter 100 Shaw Avenue, Silver Spring, Maryland 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 01/27/2009 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part 1. Enter the disease, or con, lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Micrown Ru tured Aortic Aneurysm disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Unknown C.O.P.D. Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence o) sician and burial-transit Dementia Unknown Due to (or as a consequence of) certificate has been signed by the attending physician rector, page 2 should be detached for use as the burial Physician/Medical IF FEMALE yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Right Femoral Neck Fracture 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ∐Yes 2 🖾 No 2 🗆 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1⊠ Yes 2 No 1 x Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred ours after deau.

**I Director; An.
in by the fur-5 Pending investigation 1 □ Natural 1 ☐ Yes 2 ☑ No 01/18/2009 1537 2 1 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 3618 Littledale Rd., Kensington, MD To the Hospital within 24 hours a To the Funeral L Residence Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29c. License number MO pinan ne and address of person who completed cause of death Nen a) (Type, Print)

State Registrar

Baltimore, Maryland 21215-0036

P.O.

Records,

01/20/08/109

8600 Old Georgetown Road, Bethesda, Maryland 20814

M.D.,

Registrar's Signatur

Rosemary Chinyere Iwunze,

JAN 22

31. Date filed (Month, Day, Year)

		State of Maryland / Department of Health and M 1 - State Registrar Certificate of Death		ene 0 0 9	03306
		Decedent's Name (First, Middle, Last)	2. Date of Death		3. Time of Death
Physic /Med		BESSIE MARIE LISTON	Month 1/20	/2009	11:25a ^M
Exami		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death	1,
		Homewood Nursing Home Williamsport		Washingt	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day,)	(ear) 9. Birthp	place (State or Foreign ntry)
Director		236-18-7442	12/22	/1919 WV	
yland yland		10a. State 10b. County 10c. City, Town or Location		1	Od. Inside City Limits
Mar-f st	tor	MD Washington Williamsport			1 Yes 2 □ No
th the	Director	10e. Street and Number 10f. Zip Code	100	g. Citizen of What Cour	ntry?
23a	ral	16505 Virginia Ave. Pines 219 21795		U.S.	
er des	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
rs aft	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💥 No If Yes, Give 1 ☐ Yes 2 💥 No Specify: Year or Dates:		Specify: Wh	ite
itied within 72 hours after death with the Maryland filed within 72 hours after death with the Maryland Hyglene. Thyglene. The Marileal Evantire or trans 23a or 28a-1 show ent, the Marileal Evantire or matter at	l pe	15. Decedent's Education 16a. Decedent's Usual Occupation	16	3b. Kind of Business/In-	dustry
hin 7.	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Give kind of work done during most of work life. DO NOT use retired)	ing		
Aglene Aglene Bartha	Son	8th Homemaker		Domest	ic
d oth	Be	***************************************	(First, Middle, Ma		
2 should be and Mental Is marked canamatic even	10		Dennis N		
d 2 st th and 7 Is n	1	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura Judith Likens 79 Monument Lane. F			
inc, with yiell with the Late 12-0000. I and 2 should be filed within 72 hours after death with the Maryla Health and Mental Hyglene. Item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, the Medical Examinating to mutified at		20a Mathod of Disposition 20b. Place of Disposition (Name of		1111, WV Dc. Location - City or To	25413 wn, State
Pagas nent of H ant: If its		1♥ Burial 2 □ Cremation 3 □ Removal from State		12 OL 1	
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 is marked other than any injury or other traumatic event, the Mance.	i	21. Signature of Funeral Service Licensee 22. Name and Address of Facility			Mills,WV
permit. Departinimporte any inju		Katherine Sweeter RR 5 Box 1, Bruce	neral F	lome wv	26525
		23a. Part1. Enter the disease, or complications of a caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause of each line.			Approximate Interval Between
Physician		Immediate Cause (Final disease or condition		Ç	Onset and Death
/Medical		resulting in death) a Due to (or as a consequence of):			
Examiner		Sequentially list conditions, b			
ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Chause Cities of injury			
be axecuted sician and burial-transit	хап	that initiated events c. resulting in death) Last Due to (or as a consequence of):			
be a be a sician	dical E				
The law requires that the death cartificata be axecuted the has been signed by the attending physician and page 2 should be detached for use as the burial-transitions.	edic	u.			
h cart	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of delive	ory
death	sicia	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify)		Month	Day Year
at the	hys	a Cl Oukuomu,	-		
w requires that the death cartific been signed by the attending p should be detached for use as	b	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		cco use contribute to th	
requi	eted	SJOGNEN, JANSHOME CHEFTERIA	1 🗆 Yes	2 No 3 □ Prob	ably 4 ☐Unknown
ne law has b	Completed		24a. Was an autopsy performe	prior to cor	psy findings available appletion of cause of
ician: The certificate rector, pag	_		1 ☐ Yes 2	No 1 ☐ Yes	2□ No
Physician: rthis certificaral director,	o Be	25. Was case referred to medical examiner? 1 Yes 25 No Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other: 4 Nursing House			
Phys or this aral di	I	27. Manner of D ath 28a. Date of Injury 28b. Time of 28c. Injury at	me 5 ∐ Hesideno 28d. Describe how	ce 6 Other (Specify injury occurred	/)
nding f tth. : After e tunar	atloi	1 Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No			
or Attancatter death Diractor:	Certification:	3 Suicide 6 Could not be determined determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stre City or Town,	et and Number or Rura	l Route Number,
rs afte		During, etc. (Specify)			
To the Hospital or Attanding Physician: The I within 24 hours after death. To the Funaral Diractor: Atter this certificate he completely filled in by the funaral director, paga	ledical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and control of the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the caused at the time, date	se(s) and manner as st e and place, and due to	ated. the cause(s)
Fo the	Me	29b. Signature and major certifier 29c. License number	29d	I. Date signed (Month, i	Day, Year)
. , , ,		Magle Merical Inegan DOOG		1/20/200	9
	2	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Hacentre	TOTAL SUL	904
	ate	31. Date filed (Month, Day, Year) JAN 2 3 2009 32. Registrar's Signature	100.00	-will	
Regist	trar	Ceren p. Marie			*

4b. City, Town, or Location of Death

Westminster

11:46 a M

4c. County of Death

Carroll

Physician /Medical Examiner

4a. Facility Name (If not institution, give street and number)

Carroll Hospice Dove House

Director "natural", or items 23a or 28a-f show edical Examiner must be notified at death v 2 should be filed within 72 hours after and Mental Hygiene.

Is marked other than "natural", or itel traumatic event, the Medical

Saltimore, Maryland 21215-0036

Physician /Medical Examiner

The law requires that the death certificate be executed attending physician and I for use as the burial-tran been signed by the should be detached certificate has b rector, page 2 sh or Attending Physician: funeral director, After this s after deau... Hospital

Division or Vital Records, P.O. Box 68760,

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Year) 9. Birthplace (State or Foreign Country) Maryland Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1**%** M 2□ F 89 Nov 21, 217-03-9951 1919 Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits Carroll 1 Yes 2 □ No Maryland Taneytown Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 139 Saddletop Drive 21787 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: white Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Food Market Truck Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ralph J. Loudenslager Emma Zile ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2: Department of Health at Important: If Item 27 Is any injury or other trauonce. Elizabeth Loudenslager, wife 139 Saddletop Drive, Taneytown, MD 21787 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 1/23/2009 Sykesville, MD Lake View Mem Park 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Myers-Durboraw Funeral Home R. 2 rochail 91 Willis Street, Westminster, MD 21157 23a. Part1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheek, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sarcoma Due to (or as a consequence of): disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown ut not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy perform 1∐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) DOVE HOUSE 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 🕵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific WIL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10

DHMH 17 Rev 1/2001

State Registrar

To the h

STONER

295

32. Registrar's Signature

FRE 151

31. Date filed (Month, Day, Year)

AUE

WESTHINSTER

State of Maryland / Department of Health and Mental Hygiene 2 1 1 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Donald Joseph Long January 2009 10:30 p M

Birthplace (State or Foreign Country)

10d Inside City Limits

1XYes 2 □ No

Maryland

white

USA

Month

1 ☐ Yes 2 ☐ No

Physician /Medical **Examiner**

4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 519 W. Main Street Emmitsburg Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 X M 2 □ F 86 Director 214-34-2249 Aug 17, 1922 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County show 7 Is marked other than "natural", or items 23a or 28a-f st traumatic event, the Medical Examinar must be refilled Maryland Frederick Emmitsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 519 W. Main Street 21727 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11 Marital Status 14. Race - American Indian 1 □Yes 2♥ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: <u>چ</u> Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Machinist Shoe Factory permit. Pages 1 and 2 should be filed 1 Department of Health and Mental Hygic Important: If item 27 Is marked other I any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Grant Joseph Long Emma Grace Miller ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marilyn R. Long, wife 519 W. Main Street, Emmitsburg, MD 21727 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Resthaven Mem Gardens Frederick, MD 2009 22. Name and Address of Facility Myers-Durboraw Funeral Home 21. Signature of Funeral Service License 210 W. Main Street, Emmitsburg, MD 21727 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) porue /Medical Due to as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1∐Yes 2DHNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1∐ Yes 2 **1** No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 □Yes 2 □No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Yertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD PA 023802E 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KAMSLER

mo

32. Registrar's Signature

Registrar

State

DAVID

31. Date filed (Month, Day, Year)

JAN 20

Amended Item 19a per F.D. 01/20/2009 Carroll County, wj1 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Doris Ruth Leister January 15, 2009 10:40 p M /Medical 4a. Facility Name (If not institution, give street and number)
905 Berrymans Lane 4c. County of Death 4b. City, Town, or Location of Death Examiner Reisterstown Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year Apr 17, 19 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country)
Maryland **Funeral** 216-22-7625 1 □ M 2 💢 F 81 1927 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Reisterstown Maryland Baltimore 1 ☐ Yes 2X No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 905 Berrymans Lane 21136 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by Specify: white 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Packer Parts Factory 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Oliver A. Eckard Ada E. Starner ٩ banamMis NHorishsin Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lana M. Horicks, daughter 905 Berrymans Lane, Reisterstown, MD 21136 20b. Place of Disposition (Name of Sciental Programme) South Carroll Crematory 1/17/2009 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Winfield, MD 22. Name and Address of Facility Myers-Durboraw Funeral Home 21. Signature of Funeral Service Licensee 91 Willis Street, Westminster, MD 21157 K Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** one obstructive disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Por Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached 1 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe 2 No 3 Probably 4 Unknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy performed?

1 Yes 2 (No certificate To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director; After this certifica funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🔼 No Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) WJL 001663 mi Vincent J. Fiocco, Jr., 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 est. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Museum

9-00892 Sary Edward Lu	ıcas	Please Type or Print in Black Indelible State of Maryland / Department			ible.	
Physici		1-For State Registrar 1. Decedent's Name (First, Middle, Last)			. No. 200	9 0331
Medical Exami		GARY EDWARD LUCAS			Day Year 2009	1220 hrs
	Ť	4a. Facility Name (if not institution, give street and number) Route 219 1/4 mile South of Sand Flat	4b. City, Town, or Location of Death Oakland	1	4c. County of Death Garrett	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs		(MM/DD/YYYY) 9. Birti Foreigi	
Director		218-50-0478 1 M 2 F 59 Y	Months Days Hours Min	11 04 1	1949 Co.	intry) MARYLAND
id how any te.	_	MD ALLEGANY FROSTBURG				10d. Inside City Limits 1 Yes 2 No
th the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number 174 W. FIRST STREET	10f. Zip Code 21532		. Citizen of What Coun	try?
bours arter death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once	Funeral	1 Never Married 2 Married Armed Forces?	Was Decedent of Hispanic Origin? (Spf Yes, specify Cuban, Mexican, Puerto		14. Race - Americ White, etc.	
rs aiter ural", e	by	or Dates:	Yes 2 No specify: lent's Usual Occupation (Give kind of v	work done	Specify: WT	JUTE
2 3 -	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	most of working life. DO NOT use reti	ired)	HEALTH SYS	
21215-0036 uld be filed within 7 Mental Hygiene. nuarked other than e event, the Medica		17. Fatner's Name (First, Middle, Last)		e (First, Middle, Ma	aiden Surname)	
	To Be	GEORGE LUCAS 19a. Informant's Name/Relationship (Type, Print) 19b. Mail	BERNICE ling Address (Street and Number or I		er, City or Town, State,	Zip Code)
e, MD and 2 sho Health and item 27 is			W. FIRST STREET			
es]		20a, Method of Disposition 20b. Place of Disposition Removal from State FROSTBURG	position (Name of cemeter), other place) G MEM PARK 02-0		20c. Location - City or FROSTBURG,	
Baltimc permit Page Department Important: injury or ot		4 Donation 5 Other Specify:	. Name and Address of Facility SO			
		Han M Sowers Moas 47 8	60 W. MAIN STREET	FROSTBU	RG, MD 2153	32
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*	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
xecuted n and l - transit	cal Ex	d				
ਤ ਛ	edic	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy			Lood Data of deliver	
ion of Vital Records, P.O. Box 68760, tending Physician: The law requires that the death certificate be exeath. For After this certificate has been signed by the attending physician the ftuieral director, page 2 should be detached for use as the burial.	Physician/Medi	23b. Was decedent pregnant in the past 12 months?	Fetal death 3 Ectopic pregna Other (Specify)	ancy	23d. Date of delivery Month D	ay Year
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Division of Vital Records, ral or Attending Physician: The law requirers after death all Director: After this certificate has been siled in by the funeral director, page 2 should be	Completed by			24a. Was an autopsy perform	prior to coned? death?	copsy findings available ompletion of cause of
Vital Rec ysician: The his certificate director, page	BeC	25. Was case referred to medical examiner?	26.Place of Death (Check			
of Vit ing Physic After this uneral dire	ို	examiner / 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie 27. Manner of Death 28a. Date of Injury 28b. Time of			esidence 6 🗸 Others	Scene
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ivis or At after d Direc	Certification:	3 Suicide 6 Could not be determined (Specify) Major Road / Highwa		or Town, Sta	reet and Number or Ru lite) mile S of Sand Flat,	
Div To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the best of my knowledge, death occurrence one) 2 Medical Examiner: On the basis of examination and/or investigand manner stated.				
L S L O	ž	29b. Signature and title of certifier	29c. License number	*	29d. Date signed (Mor.	
		30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.		January 31, 2009	,
	ļ	Patricia Aronica-Pollak MD. Assistant Medical Examiner	111 Penn Street, Baltimor	re, MD 21201		
S Regis	ate trar	31. Date filed (Month, Day, Year) 2009 32. Registrar's Signature	arles			
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Registrar DHMH 17 Rev 1/2001) OCME 2006

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			for State Registrar 1—28—09Amen	State	of Marylar	nd / Depa	artment of	Health and		21	200	02211
25			Registrar 1 – 28 – U9AMEN 1. Decedent's Name (First, Middle		NIONIBLICA	sur cei	tilicate o	Deam	2. Date of De	Reg. No.	109	0 3 3 1 1
	Physici	an		,					Month	Day	Year	3. Time of Death
-	/Medic		LOSSIE M. MITC 4a. Facility Name (If not institution)		umber)		4h City Town	, or Location of Dea	1/17/		nty of Death	7:34 a [™]
	Examin	er							a (•	
	Funeral		Future Care Nur 5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	Clint	ar If Under 24 Hrs	8. Date of Bir	th	ce Geo1	rge's ace (State or Foreign try)
	Director		577-52-3132	1 □ M 2 🙀 F	77	Yrs.	Months Day	s Hours Min	(Month, Da			
A COLUMN	70		Usual Residence of Decedent						13/10/1	931	PATTII	g Hope, NC
	how at		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation				10	Od. Inside City Limits
	a-fs	cto	Maryland Prince	George's	Te	mple H	ills					1 A Yes 2 No
	or 28	Director	10e. Street and Number				10f. Zip Code	•		10g. Citizen o	of What Count	ry?
	23a ust b	la l	3903 Canterbury	Way			2074	8	Ţ	United	States	
	r deg	Funeral	11. Marital Status	Armed F		I.S. 13.	Was Decedent of Yes, specify Co	f Hispanic Origin? (S Jban, Mexican, Puel	Specify Yes or No to Rican, etc.)		lace - America lack, White, e	
36	or i	by Fi	1 ☑ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	if Yes, C	2⊠ No Bive		I∐Yes 2XIN	o Specify:		Spec	cify: Bla	ck
215-0036	hours after death with the Maryland tural", or items 23a or 28a-f show at Examiner must be notified at			Year or	Dates:	16a Dasse	tont's House Oss	unation		10h Kind of	Dunings //p.d	
က်	n 72 "na" edic	Completed	15. Decedent (Specify only highes	t grade completed		(Give	lent's Usual Occ kind of work dor DO NOT use reti	ne during most of wo red)	rking	TOD. KING OF	Business/Ind	ustry
7	withi ene. than he M	шC	Elementary/Secondary (0-12)	College	(1-4or 5+)		keeping	,		Librar	v of C	ongress
N O	filed Hygi ther	ŏ	17. Father's Name (First, Middle, I	_ast)		House	Reeping	18. Mother's Na	me (First, Middle		•	31161 000
yland	d be ental ced o	o Be	112112 - March - 11	,				Nannie			,	
₹	shoul or Mark mark	욘	Willie Mitchell 19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailir	a Address (Stre	et and Number or R	0	er. City or Tow	vn. State. Zin	Code)
Ma	nd 2 s ith ar 27 is 1 trau	1	Freda Y. Walker		ter	T		ury Way T				,
ā,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition	/ Daugh	20b.	Place of Dispo	sition (Name of	1	Date		n - City or To	
saltimore,	ages ent of it: If i		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sc		n State ₩as	shingto	natory or other p n Nat 1	Čem.	7/2000	0	1 . 1 . 1	
	artme ortan Injur		21, Signature of Funeral Service I	- 4	11111		emetery Name and Add	- 1/2 dress of FacilityPo		Suitla		
ñ	Dep Imp any), I)	Knit a	Augus	0 MU10			oro Pike				
m	4		23a. Parl 1. Erfter the disease, or shock, or heart failure. List	complications that	caused the deal						101 / 101	Approximate
	Dhanistan	4	shock, or heart failure. Light	only one cause on	each line.				, , ,			Interval Between Onset and Death
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ם	death e atten	icia	in the past 12 months? 1 ☐ Yes 2 ☑ No	4□Preg	birth 2 Feta gnant at time of c		lEctopic pregnal] Other <i>(specify)</i>				Month	Day Year
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,	requires that the een signed by the rould be detache	by P	Part II. Other significant conditio	ns contributing to	death but not res	ulting in the ur	nderlying cause	given in Part I.	23e. Did t	obacco use co	ontribute to the	e cause of death?
Ë	equire en siç outd b		COLON CANCER						1 🗆	Yes 2□ No	3 ☐ Proba	ably 4 🛣 nknown
Records,	aw re	Completed							24a. Was		b. Were autop	sy findings available
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N Ea	sician: The law certificate has b irector, page 2 s	a)	25. Was case referred to medical	4				26. Place of De	ath Check onl		i 🗆 i es	E 140
	Physician: this certific	.0 B	examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1	Inpatient 2] ER/Outpatien	t 3 DOA	M	Home 5 ☐ Resi		Other (Specify)
0	g Ph ter th neral	Ë	27. Manner of Death		e of Injury nth, Day Year)	28b. Time of Injury	28c. In		28d. Describe			
<u></u>	Attending r death. ector: After by the fune	atio	1 Natural 5 Pending 2 Accident investig	ation	mii, Day Tear)	Ingary		☐Yes 2☐No				
UNSION	Atte	ific	3 Suicide 6 Could n 4 Homicide determi	and 28e. Plac	e of injury - At h	ome, farm, str	eet, factory, offic	е	28f. Location (Street and Nur	mber or Rural	Route Number,
5	tal or s afte al Di	Certification:			amigi oto. (opoon	.,,			Only or Tol	an, orare)		
	To the Hospital or Attending Physician: The within 24 Hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical (29a. Certifier 1 ☐ Certifying (Check only one)	Examiner: On the	basis of examina	owledge, death ation and/or in	occurred at the vestigation, in m	time, date and plac y opinion, death occ	e, and due to the urred at the time,	cause(s) and date and plac	manner as sta e, and due to	ated. the cause(s)
	ithin i	Mec	29b. Signature and title of certifier	and ma	nner stated.		29c. Lice	nse number		29d. Date sigi	ned (Month, L	Day, Year)
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	_		30. Name and address of person v	who completed ear	ise of death (It	n 23a\ /Tuno	D 51	.520		1/19	9/2009	
_	0							ahi-a	ח כי מי	0033		
	Sta	te	Bahram Pishdad N 31. Date filed (Month, Day, Year)	32.	Registrar's Signa	ature	D.E. Wa	shington	р. С. 21	0034		
	Registr		JAN 2 2 2009	Brown	Registrar's Signa	Ken						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician 2009 12:24p Agatha E. Meadows Jan. 15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fort Washington Prince George's Fort Washington Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number Date of Birth (Month, Day, Year) **Funeral** Months Days 1 M 2 F Director 2/12/1912 579-07-1978 Virginia Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10a. State 10d. Inside City Limits Prince George's Temple Hills 1 √ Yes 2 □ No Director Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? filed within 72 hours after death with a or 23a USA must 2600 Buckner Lane 20748 Funeral items ? 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian "natural", or iten idical Examiner Black, White, etc. 1 Yes 2 K If Yes, Give Year or Dates 1 Never Married 2 Married 2 No Maryland 21215-0036 1 ☐ Yes 2X No Specify Black þ Specify: 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the M Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Medica1 marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ges 1 and 2 should be file it of Health and Mental Hi if Item 27 Is marked oth Be William Anderson Emma Ward ٩ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: if Item 27 any injury or other tr once. <u> Shirley Carr - Niece</u> 2600 Buckner Lane, Temple Hills, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Memorial Cem. 1/23/2009 4 □ Donation 5 □ Other (Specify) Suitland, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd., Brentwood, MD 20722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Respirator /Medical Due to (or is a consequence of): Examiner Sequentially list conditions, if any, leading to influential cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a consequence of) Examiner requires that the death certificate be executed Corone burial-trar Due to (or as a consequence of): or Vital Records, P.O. Box 68760, physician Physician/Medical the as attending IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Year 4□Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? Yes 21 No certificate I Physiclan: director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes & No 1 Inpatient 2/X ER/Outpatient 3□ DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d, Describe how injury occurred After Division Hospit or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No hours after dea'h. uneral Director. A 2 Accident in 24 hours.

the Funeral Directory of the fulled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 hou To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifia 29c. License number 29d. Date signed (Month, Day, Year) D0053117 30. Name and address of person who co resed cause of death (Item 23a) (Type, Print) Patrick E. Daly, 11711 Livingston Rd., Ft. Washington, MD State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 03313 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death - Month Day **Physician** Elizabeth Diane Matthews 2009 22:22 /Medical January 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Cheverly Prince George's 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 12 F Director 212-64-6446 1956 Washington, DC April 10. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, The Medical Evantic rust by notified at once. 10a State 10h County 10c City Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Prince George's Mount Rainier 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 3107 Varnum Street Funeral United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🙀 No Specify Completed by Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Unemployed None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ William H. Matthews Mary E. Burton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle Matthews - Niece 3511 Windom Road #5 Brentwood, MD 20722 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Lee's Crematory Jan 22, 2009 Clinton, MD 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road, NE Washington, DC 20019 23a. Part I. Er ter the disease, or complications that caused the fleath, shock, or heart failure. List only one cau ell a each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to for as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Library 1997) that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be execu Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 honths? 23d. Date of delivery 3 Ectopic pregnancy Day 4 ☐ Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably . 1 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only onle) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Yes 2 □ No 2 ☐ ER/Outpatient 3 ☐ DOA Inpatient After this Certification: To May ner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury Natural 1 ☐Yes 2 ☐No Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide e Funeral I

Division of Vital Records.

State Registrar

Medical

29a, Certifier

30. Name and

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, JAN 2 2 2009

32. Registrar's Signature

person who completed cause of death (tem 23a) (Type/Print)

and manner stated.

within 2

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

09-00788 Howard May Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Top State Top County Top	ward May			ertificate of Death		Reg. No.	109 03
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Physician aminor 20	altir	45c 11	21: Signature of Funeral Service Licensee		Facility TH 4111 PA A	ve. Suitlan	d, MD 2074
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Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201				O.C.M.	.E.	January 27,	2009
Wally C. Haple M.B. Bopely	1			(Item 23a) Examiner 111 Penn Street F	Baltimore, MD 2120	1	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 0015 M MOLINO ATRICIA 01 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Mandrin Chesapeake Hospice Harwood Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2 7 F 219 82 9362 Director 1960 Califorina Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10h County 28a-f show s 23a or 28a-f show 1 □Yes 2√X Maryland Prince George Directo Clinton 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 6003 ClintonWay 20735 United States Funeral Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23 Lry or other traumatic event, the Madical Exprimer must Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housekeeping Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Molino Sr. Geraldine Southard ဥ 19a. Informant's Name/Relationship (Type. Print)
Geraldine Myers (Mother) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 Is
any Injury or other trau
once. 6003 Clinton Way, Clinton, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 X X remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory Jan 12,2 009 Clinton, Maryland 21. Signature of Funer I Syrace Like 22. Name and Address of FacilityLee Funeral Home, Inc 6633 01d Alexandria Ferry Road, Clinton, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) year **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Exam burial-trai Due to (or as a consequence of): physician s the burial Division of Vital Records, P.O. Box 68760, Physician/Medical ending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 ☐ Other (specify) signed by the a 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an certificate ha 2 No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred HUUSE 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No reral Director; / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral D

completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12,2009

Registrar

State

ANNAPOLISMD 21401

Name and address of person who completed cause of death (Item 23a) (Type,

31. Date filed (Month, Day, Year)

JAN 2 Z 2009

GENTA W

32/ Registrar's Signature

445

State of Maryland / Department of Health and Mental Hygiene

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

		1 - State Registrar		Cer	rtificate of i	Death	1	Reg. No. C	109	0331	D
		1. Decedent's Name (First, Middle, Las	st)				2. Date of Dea	ath		3. Time of Death	_
Physicia /Medic		Wayne McClain	Martin				Month Januar	y 23, 2	Year 1009	4:45 P	Λ
Examin		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, o	r Location of Death			ty of Death		_
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Funeral		Social Security Number 6. S		ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	th v Year)	9. Birthp Coun	lace (State or Foreigntry)	jn
Director		218-16-4665	X ^{™ 2 □ F} 86	Yrs.	World Days	Tiodio IVIIII.	Dec 29			yĺand	
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shov	<u>.</u>	10a. State 10b. County	10c. City	, Town or Lo	cation				10	0d. Inside City Limit	
Ba-f	cto	MD Garrett	0al	kland						1 □ Yes 2 😿 No	_
or 2	Directo	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Coun	try?	
238	ra I	123 Steyer Mine R	pad		21550			United	State	es	
tems	Funeral I	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	5. 13. V	Was Decedent of H fYes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puert <i>o</i>	ecify Yes <i>or</i> No- Rican, etc.)	- 14. Ra Bla	ice - America ack, White, e		
o.	by F	1 ☐ Never Married 2 ☐ Married 3X Widowed 4 ☐ Divorced	1 ∐Yes 2 X No If Yes, Give	1	I□Yes 2ไDNo	Specify:		Speci	fy:		
uraf			Year or Dates:	16a Dagge	ient's Usual Occup	ation		16b. Kind of E	Whit		_
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than than	ЩĆ	Elementary/Secondary (0-12)	College (1-4or 5+)	Owne		-)		Coal	Mine		
Hygi ther ant,		17. Father's Name (First, Middle, Last)		OWIII		18. Mother's Name	e (First, Middle,				_
ental ced c	o Be	William Cline	Martin			Ada Blaı	iche Bac	chtel			
mari mati	ဥ	19a. Informant's Name/Relationship (19b Mailin	a Address (Street	and Number or Rur			. State. Zin	Code)	
Ith ar		Dianna Everd, Dau				ine Road,			21550		
Hea tem other		20a. Method of Disposition	20b. PI	ace of Dispos	sition (Name of	; ;	Date	20c. Location		wn, State	_
Department of Health and Mental Hygiene. Important: or items 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar mast be rediffied at once.		1 Burial 2 Tremation 3 1	Hemoval from State	-	natory or other plac		/2000	C	1 3	MD	
artme ortan injur		4 □ Donation 5 □ Other (Specification 21. Signature of Funeral Service Licen				ory: 1/26,		Cumber		MD	_
Depar Impor any ir once		- 11	1. T		David A.	ss of Facility Burdock	Funeral	l Home,	P.A.		
		23a. Part 1. Enter the disease, or com	plications that caused the death	Do not ente		cond St.			21330	Approximate	_
		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.				A			Interval Between Onset and Death	
ıysician Medical		disease or condition resulting in death)	, a		Nonz	x Avter	V	isere		463V	_
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phy s the	/Medical		, G								
nding Ise a	_	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar					23d, Da	ate of delive	HTV	
atte I for i	Physiciar	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de		Ectopic pregnanc Other (specify)	У				Day Year	
by the	λ	9 Unknown	9 ☐ Unknown								
ned t	by PI	Part II. Other significant conditions of	ontributing to death but not resu	Iting in the ur	nderlying cause give	en in Part I.	23e. Did to	bacco use con	tribute to th	ne cause of death?	
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shou	Completed		1 d . l . 1	lo h	, l		24a. Was a	an 24b.	Were autor	psy findings availabl	е
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s cer	O B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ I	EB/Outpatien	t 3 DOA Oth				ther (Cassif		
er thi	-	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injur Worl		28d. Describe h			7	_
ath.	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year)	Injury		K? Yes 2 □ No					
ecto by th	ific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify	me, farm, stre	eet, factory, office				ber or Rura	l Route Number,	
s afte	Certification:	4 Hottlidde	building, etc. (Specify	'/			City or Tow	m, State)			
hour uners		29a. Certifier 1 Certifying Ph	nysician: To the best of my knowniner: On the basis of examinat	wledge, death	occurred at the time	me, date and place,	and due to the	cause(s) and m	nanner as st	tated.	
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atten completely filled in by the funeral director, page 2 should be detached for us	Medical	one)	and manner stated	ion and/or in	vestigation, in my d	pinion, death occur	red at the time,	date and place	, and due to	the cause(s)	
To t	Σ	29b. Signature and title of certified			29c. Licens			29d. Date signe	ed (Month, L	Day, Year)	
		Tho	un la John	m	_ j	21233	3	1 / 4	1016	1-1	
	10	30. Name and address of person who								1	
	Y	Dr. Thomas G. Jo			4th Stree	et, Oakla	nd, MD	21550			_
Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signati	ure	a de 1						
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		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. C	County of Death
,	Ц		nce George's
Funeral Director			9. Birthplace (State or Foreign TRINGAISAIS Country)
Bilector		Usual Residence of Decedent 231-98 3320 1 M 2 F 43 Yrs. Months Days Hours Min.	Country)
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Aaryka 28a-f Lator	ecto	10e. Street and Number 10f. Zip Code 10g. Citizer	n of What Country?
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sho and 7 is matic	7	JACKIE ALLETTE SISTER 1016 JANSEN AVE CAPITOLI	HATS MD 20743
	ı	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Lot	cation - City or Town, State
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Baltin permit, Departm Imports	1	21. Signaturi Funeral Service Licensee 22. Name and Address of Facility John T. PHINES	FUNERAL HOME LC
O SO E	10	GLEAN ME BOOK 12TH ST. N.E. WASHINGTO	N. DC 20017
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Box 68760, e death certificate be exenter attending physician ed for use as the burial -	Physician/Medi	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy MM	Date of delivery Nonth Day Year
lox 68 leath certileath certiles e attending for use as	ciar	25b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy M 4 Pregnant at time of death 5 Other (Specify)	Month Day Year
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cords, aw require has been a 2 should	plet	autopsy performed?	prior to completion of cause of death?
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tal Rectinan: The certificate ector, page	Be	25. Was case referred to medical examiner? Other: Other:	
Division of Vital Records, P.O tal or Attending Physician: The law requires that trs after death. "I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact	P	1 Ves 2 No Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence	ce 6 Other: Scene
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To the Hos within 24 h To the Fur	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and manner stated.	
	Σ	1	ate signed (Month, Day, Year)
		Moder My ling IR. m.d.	ary 26, 2009
		30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
//			

		State of Maryland / Department of Health and Months 1 - State Registrar	ental Hygiei Reg.i	
Physicia /Medica			2. Date of Death	Day Year 3. Time of Death
Examine	er	4a. Facility Name (If not institution, the street and number) 4b. City, Town, or Location of Death Vas hing for Adventist Hospital Takema Park, A	20	4c. County of Death Mondgomery
Funeral Director		579-18-4479 1□ M 2X F 87 Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year Feb. 26,	
Sa-f show	Director	Usual Residence of Decedent		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
23a or 21		10e. Street and Number 9718 Hedin Drive 10f. Zip Code 20903	10g.	Citizen of What Country? USA
0,18	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Novidowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
jiene. r than "natur the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales	g	Kind of Business/Industry
fental Hygrked other	To Be C	17. Father's Name (First, Middle, Last) Walter Thomas Magruder 18. Mother's Name (Corrie)	(First, Middle, Maid	
alth and N 27 is man er traumal		19a. Informant's Name/Relationship (Type. Print) James E. Owens/Son 19b. Mailing Address (Street and Number or Rural 9718 Hedin Drive, Silve		
nent of He int: If Item iry or othe			n. 23,	Location - City or Town, State ckville, Maryland
Departm Importa any inju once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins H	Funeral H	ome Inc. lver Spring, MD 20901
nysician Medical caminer	iner	23a. Part 1. En ar the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Due to (or as a consequence of):		Approximate Interval Between Onset and Death
physicia the bur	dical Ex	Cause (Disease or injury that initiated events resulting in death) Last C		
by the attending ached for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Mo 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
en signed und be det	2	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. End Stage heart disease		o use contribute to the cause of death? 2 No 3 Probably 4 Minknown
icate has bei	Completed	Congestire Heart Failure	24a. Was an autopsy performed?	
is certif	0 26	25. Was case referred to medical examiner? 1 Ses 2 No Acclined Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other: 4 Nursing Home	•	6 ☐Other (Specify)
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Certification: I	27. Manney-of Death 1	3d. Describe how inj	ury occurred and Number or Rural Route Number.
n 24 hours ne Funeral pletely fille	edical C	29a. Certifier (Check only one) 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, are considered and place, and manner stated.	nd due to the cause d at the time, date a	s(s) and manner as stated. and place, and due to the cause(s)
	Ξ	29b. Signature and title of certifier 29c. License number 00067249	,	Date signed (Month, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John M. Sasser ND 7600 (Gyrall Arenne, 31. Date filed (Month, Day, Year) JAN 22 2009 Aren J. Janes	Takema	Park, 10 209/2
State Registra	1	JAN 2 2 2009 December 1. parker		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) January 20, 2009 **Physician** Poole Elizabeth Pauline /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Charles Charles County Nursing & Rehab. Center LaPlata If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Virginia 8. Date of Birth Aug. 1, 1922 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Months Days Hours 1 M 2 KF 86 Director 579-24-2467 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10a. State event, the Medical Examiner must be notified at **Funeral Director** White Plains items 23a or 28a-f Maryland Charles 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20695 USA 10722 Willetts Crossing Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 22∑No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 XXIo Specify. Be Completed by Specify: 3₩Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11th Homemaker In Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) pe ntal of Health and Menta Item 27 is marked Letcher Laura Alice Whittaker Frank Harvey Pages 1 and 2 should nent of Health and Men ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lois J. Tayman / Daughter 10722 Willetts Crossing Road White Plains, Maryland or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any Injury or ot 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Jan. 24, 2009 St. Barnabas Church Cem. Temple Hills, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 21. Signature Funeral Service Licensee 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** nou mani /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical 23d. Date of delivery

or Attending Physician: The law requires that the death certificate be executed P.0. icate has been signed , page 2 should be det Division of Vital Records, þ Completed Be Certification: To this after death. à

IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 25. Was case referred to medical

Ho

5 Pending

investigation

6 Could not be determined

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

Day

the cause(s)

12:07 A M

10d. Inside City Limits

Approximate Interval Between Onset and Death

White

1 ☐ Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an autopsy 2XXNo 1 🗆 Yes 26. Place of Death (Check only one)

S	pital	1 ☐ inpatient 2	⊇ ☐ ER/Outpatient	3 🗆 [AOC	Other:	4 K Nursing H	ome	5 Residence	6 ☐ Other (Specify)
	28a.	Date of Injury (Month, Day, Year	28b. Time of Injury	М	28c.	Injury at Work? 1 □ Yes	2 🗆 No	28d.	Describe how inju	ury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)							28f.	Location (Street a City or Town, Sta	and Number or Rural Route Number, te)	

29a. Certifier (Check only one)	2☐ Medical Examiner: (th occurred at the time, date and place, and due to the time of th	
29b. Signature and	Nitle of certifier	29c. License number	29d. Date signed (Month,

00052919

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) State Registrar

examiner?

27. Manner of Death 1 X Natural

2 Accident

3 Suicide

4 ☐ Homicide

1 ☐ Yes 2.KNo

32. Registrar's Signature

filled in 24 hours

within 2.

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-00805 State of Maryland / Department of Health and Mental Hygiene 2009 03320 Eric Lafavette Payne Certificate of Death 1- For State Reg. No. Registrar Time of Death 2. Date of Death Decedent's Name (First, Middle,Last) Month Day January 27, 2009 Physician/ 1235 hrs Medical Examiner LAFAYETTE PAYNE c. County of Death 4b. City, Town, or Location of Death, 4a. Facility Name (if not institution, give street and number) Howard Columbia Howard County General Hospital 9. Birthplace (State or 8. Date of Birth (MM/DD/YYYY If Under 1 Year | If Under 24Hrs. 7. Age (in yrs. last birthday) 5. Social Security Number Foreign WASHINGTON Country) **Funeral** Min Davs Hours Months Director 579-06-3455 Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 1 X Yes 2 No 28a-f show ELLICOTT s 23a or 28a-f sho HOWARD MD 10g. Citizen of What Country Director 10f. Zip Code 10e. Street and Number 21043 IISA 8524 HARVEST VIEW COURT 14 Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. the Medical Examiner must be Armed Forces? Never Married 2 X Married Yes ^{2}X 5 Specify BLACK Yes 2 X No specify: If Yes, Give Year Widowed Divorced "natural" þ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 nd 2 should be filed within 72 lath and Mental Hygiene. marked other than PRIVATE LOAN OFFICER 4YRS 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last JOYCE JORDAN LAFAYETTE PAYNE Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21043 19a. Informant's Name/Relationship (Type, Print) 2 8524 HARVEST VIEW COURT ELLICOTT CITY, MARYLAND TANISHA PAYNE/WIFE Pages I and 2 sho ment of Heakh and faut: If item 27 is or other traumat 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State Department o
Important: 1
injury or oth RIVERDALE CREMATORY /2/2009 RIVERDALE, MARYLAND Donation 5 Other Specify 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME permit. Departm 21. Signature of Funere Sorvie Licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Apploximate Interval Between Onset and **Physician** failure. List only one cause on each line. Death Medical a. Hanging Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): requires that the death certificate be executed and 23a,27,28a-f,perME, g889 3/30/09 TT Physician/Medical AMENDED physician a the burial -X UNPENDED 23d. Date of delivery Box 68760 23c. If yes, outcome of pregnancy IE FEMALE: Day Year 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I o Yes 2 No 3 Probably 4 ✔ Unknown ģ Completed 24b. Were autopsy findings available 24a. Was an Records, prior to completion of cause of autopsy death? performed? No ✓ Yes 2 1 🗸 Yes 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death 25. Was case referred to medical of Vital Be Other₄ Hospital: 1 Nursing Home 5 DOA Inpatient 2 V ER/Outpatient 3 1 V Yes 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day, Year 27 Manner of Death Certification: subject hanged self Yes 2X No Natural Fd 1132 hrs Division Pending Fd 1/27/09 Director: the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 8524 Harvest View Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be 3 X Suicide Ellicott City, residence determined (Specify) Funeral Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical To the F and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier January 28, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Russell Alexander MD. 32. Register's Signeture 31. Date filed (Month, Day Year) State Registrar

DHMH 17 Rev 1/2001 OCME 2006

WUISIE

		Registrative UH29aper	NP,1-22-09,EMW,			rtificate of			giene ₍ Reg. No.	2007	0332
Division		1. Decedent's Name (First, Middle	, Last)					2. Date of De	ath	Vons	3. Time of Death
Physi /Me/	dical	Elisa Rivas E	Pearson					Janua	ry 20	, 2009	12:01a
Exam		4a. Facility Name (If not institution, Nursing Facilit	y at			4b. City, Town, o	Location of Death	1	4c. C	ounty of Death	
		Johns Hopkins E		cal Ce		Baltin	ore If Under 24 Hrs.	8. Date of Bir		Baltimo	re place (State or Foreign
Funera Directo		263-36-4745	1 M 2 T F 8		Yrs.	Months Days	Hours Min.	Nov. 1	y, Year) 3, 1 9	Cou	intry)
	,,,	Usual Residence of Decedent						NOV. I	J, 19	20 110	rida
yland Now		10a. State 10b. County		10c. City, To	own or Lo	cation		·- <u></u>			10d. Inside City Limit
Mar.	ģ	Maryland Mc	ntgomery		Silve	er Spring	r				1 □Yes 2 X N
h the	ire	10e. Street and Number				10f. Zip Code			10g. Citiz	en of What Cou	ntry?
th with	a 🗆	2704 Woodedge	Road			20	906			USA	
72 hours after death with the Maryland natural", or Items 23a or 28a-f show dical Evarrings must be notified at	Funeral Director	11. Marital Status		1 ∏Yes 2 TxNo		13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ No Specify: Spar		pecify Yes or No	- 1	4. Race - Amer	
or Ite	교	1 ☐ Never Married 2 🔀 Marri	ed 1 ∐Yes 2 📆 N							Black, White, etc.	
ours ral",	9	3 Widowed 4 Divorced	Year or Dates:							Specify: White	
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ould I Mer narke	မ	Manuel Rivas						a Casal			
2 sh n and ris m		19a. Informant's Name/Relationsh William Pears		1		ng Address (Street					
and tealth m 27						4 Woodedg	e Koad,				
ges 1 t of F if ite or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 ☐ Removal from State	20b. Place	e of Dispo etery, cren	sition (Name of natory or other plac	ce)	Date n. 24	20c. Loc	ation - City or T	own, State
Fant:		4 ☐ Donation 5 ☐ Other (Sp		Gate		Heaven Ce	metery	2009	Silv	er Spri	ng,Maryla
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, The Medical Evarting rough populated at	once	21. Signature of Funeral Service L	icensee		F1	Name and Addre cancis J. OO Univer	Collins	Funera	L Hom Silv	e Inc. er Spri	ng, MD 20
		23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that caused	the death. D						554 - 544	Approximate Interval Between
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/Medica	_	resulting in death)	Due to (or as a								J days
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Registrar

State

31. Date filed (Month, Day, Year)

JAN 22 2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 03322 State of Maryland / Department of Health and Mental Hygiene $2\,0\,0\,9$ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ŽŠ, 8:45 P M Phillips January 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Egle Nursing Home Allegany Lonaconing If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, You Sept. 2, 9. Birthplace (State or Foreign **Funeral** 1 M 200 217-28-9151 92 1916 Maryland Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ould be filed within 72 hours after death with the Maryla Mental Hygiene.

arked other than "natural", or items 23a or 28a-f show afte event, the Medical Examinational to notified at MD. Allegany Barton 1XXYes 2 □ No Directo 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? PO Box 177 Temperance Row 21521 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11. Marital Status 14. Race - American Indian. 1 ☐ Never Married 2 ☐ Married Specify: white Baltimore, Maryland 21215-0036 1 ☐Yes 2X No ģ Specify. 3 Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housework Homemaker unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be fi Department of Health and Mental H Important: If item 27 is marked of any linjury or other traumatic even once. William D. Jobson Eshter C. Langham ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert White/ grandson 19301 Upper Paradise St, Frostburg, Maryland 21532 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State /26/ Cumberland Maryland Cumberland Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2009 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Boal Funeral Home 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Y cars disease or condition resulting in death) Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner the burial-tran and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Day Year 5 ☐ Other (specify) sate has been signed by the page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perforr Anemio 1 □Yes 1 ☐Yes spital or Attending Physician: Thours after death.
Ineral Director: After this certifical y filled in by the funeral director, pa 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1∐ Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred Division 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State Registrar (Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. S L Sandhir, 48 Tarn Terrace, Frostburg, Maryland

31. Date filed (Month, Day, Year) 32. Registrar's Signature 29d. Date signed (Month, Day, Year)

Christopher Fra		1- For State Certificate of Deat		ygiene Reg.	_{No.} 200	9 0332				
Physici Medical Exami		1. Decedent's Name (First, Middle,Last)		2. Date of Death Month	ay Year	3. Time of Death 1647 hrs				
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Funeral		3 ()	er 1 Year If Under 24Hrs		MM/DD/YYYY) 9. Bi Forei					
Director		215–94–7360 1 x 2 F 44 Yrs. Month	ns Days Hours Min	06/16/1	964 C	ountry Maryland				
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arylanı Ba-f sh	Director	MD Prince George's Glenn Dale 10e. Street and Number 10f. Zig	Code	10g	. Citizen of What Cou	untry?				
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1356 f. nore, MD 21215-0036 ages 1 and 2 should be filed within 72 hours after death with the Maryland and Offleath and Montal Hygiene. If filem 27 is worked of up than "matural", or items 23a or 28a-f show other transmatic event, the Medical Examiner must be notified at once.	eral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Deced	ent of Hispanic Origin? (S fy Cuban, Mexican, Puerto			rican Indian, Black,				
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21215-0036 unid be filed within 7 Mental Hygiene. G ked oft at than	Be	James Parota		McNamar		7 . 0 . 1 .)				
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Baltimore, permit Pages I an Department of Hee Important; If ite		4 Donation 5 Other Specify: Bayview Crem 21. Signature of Funeral Service Licensee 22. Name and	$\frac{1272}{1}$ Address of Facility $\frac{1272}{1}$	2/2009 I	Baltimore, ral nome	_MD				
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Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. The To the Funeral Directors. After this certificate I completely filled in by the funeral director, page		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the	e time, date and place, and		·					
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		Pote Uronice Vollet us	O.C.M.E.		January 31, 200	09				
		30. Name and address of person who completed cause of death (Item 23a)	lana Chroni Dellier	mo MD 04004						
10			enn Street, Baltimo	ore, MD 21201						
S Regis	tate trar	31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 0 2 2009 August B. Laura	1							

09-00875

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** CAROLYN CECELIA PETTIS 2009 JANUGY /Medical County of Death Examiner Clint an 6600 arve 8. Date of Birth
(Month, Day Year)
May 25, 1925 Maryland If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 M 2 X 216 22 2875 Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Maryland Prince George Clinton 1 □Yes XIXNo Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6600 Killarney Street 20735 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. hours after 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Black ð 3€Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Homemaker Own Home 12 should be filed what and Mental Hygien 7 Is marked other the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked any injury or other traumatic ew Ernest Dotson Mary Barnes ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris Farmer (Daughter) 6600 Killarney Street, Clinton, MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) Jan 29ate, 200 9oc. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, MD 22. Name and Address of Facility Lee Funeral HOme, Inc 6633 21. Signature of Funeral Service Licensee -mo1533 Old Alexandria Ferry Road, Clinton, MD20785 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CANTOVE Atheroschertic **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Ducity (or as a consequence of): Examine certificate be executed burial-trar Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð The law requires pe 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autonsv perform this certificate 2 No 1□ Yes or Vital To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ٩ 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Division Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JAN 2 2 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3001

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

2005

arel

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 9 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 9:28 PM Kay mond 01 /Medical 4b City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Salisbur Hospice ut Ma Wiconico If Under 1 Year | If Und Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral 0**ex 1. **2X**M 2. □ F Months Days Hours Min. 188-26-7716 72 Director PA March 12,1936 Usual Residence of Decedent 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Marical Examinat in ust be nothed at 10b. County 10d. Inside City Limits Director 1X Yes 2 □ No MD Somerset Westover 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 8911 Millard Long Road 21871 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XXYes 2 □ No Army If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Kay mond tope Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify. \$ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Manager Various 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Claude Pope 2 Maude Holloway 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret L. Pope/wife 8911 Millard Long Rd., Westover, MD 21871 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Eastern Shore
Veterans Cemetery

22. Name and Address 1 Facility
Lewis N. Watson Funeral Home 4 Donation 5 DOther (Specify) Hurlock 21. Signa up of Funeral Service Licensee 1618 West Rd., Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** END STAG DRSRASE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Agampletely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Otner (specify) P.0. 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 RUNO 3 Probably 4 ☐ Unknown Completed 1 ☐ Yes Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🖺 No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Other (Specify) Hospick 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title 29d. Date signed (Month, Day, Year) 20058410 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) PO BOX 1733 Star Brey mo 21802 PATHO Hospica Registrar's Signature WARY

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

Jan 22 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav ARCHIBALD LEVI 2:45 JAN 16 2009 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 5904 Cable Ave Springs If Under 24 Hrs. Camp George's Prince 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 504 28 1322 86 April 7, 1922 Kentucky Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 □Yes 2□No MD P.G. Camp Springs 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 5904 Cable Ave 20746 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 XYes 2 No WWIII If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Airforce Military 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Marion C. Roy Martha Delk 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edith Roy (WIFE) Cable Ave, Camp Springs, MD 20746 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Commation 3 ☐ Removal from State Lee Crematory Jan 20, 2009 Clinton, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old 21. Signature of Funeral Service Licensee 10/391 Alexandria Ferry Road , Clinton, MD 20735 23a. Parl 1. Enter the divides, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Prostate Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy

Physician /Medical Examiner

Department of important: If any injury or

Physician

/Medical

Examiner

Funeral Director

r 28a-f show notified at

an "natural", or items 23a or Medical Examiner must be

Director

Funeral

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Completed

Be

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Aut: If item 27 is marked other than "natural", or items 23a or 28a-f show aut: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notitled at

Baltimore, Maryland 21215-0036

Completed by Physician/Medical Examiner

the burial-tran

Medical Certification: To Be

use as signed by the a ate has funeral after death

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

within 24 hours a To the Funeral L

Hospital

State Registrar

1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
	24a. Was an autopsy findings availal prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical	26. Place of Death (Check only one)
examiner? 1 Yes 2 X∵X lo	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)
27. Manner of Death 1	
3 ☐ Suicide 6 ☐ Could not be determined	
29a. Certifier 1X Certifying P (Check only one) 1 Medical Exa	miner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. miner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

31. Date filed (Month, Day, Year) JAN 2 2 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

1 Court Largo MD, 20774 9200 Basi

29d. Date signed (Month, Day, Year)

20, 2009

29c. License number

Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

	State State	e of Maryland / De	-		Mental Hygier	2009	03327
	Registrar	<u> </u>	Certificate of L	eath	Reg. N	40C U U J	03321
n	Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
al	Anna B. Richardson					0, 2009	9
er	4a. Facility Name (If not institution, give street an	·	4b. City, Town, or			c. County of Death	
	Crafton Convalesce		Croft	O N If Under 24 Hrs.		Anne Ar	
	5. Social Security Number 6. Sex 1 M 2 X	7. Age (In yrs. last birtho	Months Days	Hours Min.	8. Date of Birth (Month, Day, Yea	ir) Çqi	nplace (State or Foreign untry)
	Usual Residence of Decedent	X 93 Yrs			Oct 30,	1912 N	ew Jersey
	10a. State 10b. County	10c. City, Town o	r Location				10d. Inside City Limits
tor	Maryland Prince Ge	orge Upper	Marlboro				1 □ Yes 2√TXNo
ire	10e. Street and Number	- 0 11	10f. Zip Code		10g. (Citizen of What Cou	untry?
a D	11202 Cranford Dri	vе	2077	2	Un:	ited Stat	es
ner		Decedent Ever in U.S.	13. Was Decedent of Hi	spanic Origin? (Sp	pecify Yes or No-	14. Race - Amer	
F		es 2 No , Give XX		Specify:	Tricari, etc.)	Black, White	
d b	3 XX Widowed 4 □ Divorced Year	or Dates:	1 □ Yes 2 □ No	Opcony.		Specify: Wh:	ite
lete	15. Decedent's Education (Specify only highest grade comple	ted) (C	ecedent's Usual Occupa Give kind of work done d	uring most of work	ing 16b.	Kind of Business/I	ndustry
E	Elementary/Secondary (0-12) Colle 12 2	ge (1-4or 5+)	fe. DO NOT use retired,	1		I acci	
Be Completed by Funeral Director	17. Father's Name (First, Middle, Last)	se	cretary	18 Mother's Nam	e (First, Middle, Maide	Legal	
ă	Frederick Bieber	hach			anzweiler	on ourname)	
၉	19a. Informant's Name/Relationship (Type. Print,		lailing Address (Street a			v or Town State 7	lin Code)
	Lee Richardson (Son)	11	202 Cranfor	d Drive,	Upper Mar	1boro, MI	0 20772
	20a. Method of Disposition	20b. Place of D	isposition (Name of crematory or other place		Date 20c.	Location - City or T	Town, State
	1 Burial 2 ☐ Cremation 3 ☐ Removal f 4 ☐ Donation 5 ☐ Other (Specify)	rom State		i .	000		//1 1
	21. Signature of Funeral Service Licensee	Сецаг н	ill Cemeter 22. Name and Addres			itland, N	aryland
	Marin X Mass	D1000857	Alexandria				
	Part1. Enter the disease, or complications t	hat caused the death. Do not				II. IID 201	Approximate
	shock, or heart failure. List only one cause Immediate Cause (Final	on each line.	Ametho	1 CA			Interval Between Onset and Death
	disease or condition resulting in death)	e to (or as a consequence of):	rigina	1100			
		o to (or do d consequence or).					
Jer	Sequentially list conditions, if any heading to immediate cause. Enter Underlying	e to (or as a nunsequence of)					
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	resulting in death) Last Du	e to (or as a consequence of):					
dical	d						
Med	IF FEMALE:						
an/	23h Was decedent prognant 23c. If yes	i, outcome of pregnancy Live birth 2 Fetal death	3 Ectopic pregnancy			23d. Date of deli	
Sici	1 Yes 2 No	Pregnant at time of death Jiknown	5 Other (specify)			Month	Day Year
Ph S	9 D ONKNOWN						
Completed by Physician/Me	Part II. Other significant conditions contributing	to death but not resulting in tr	ie underlying cause give	n in Part I.			the cause of death?
ted					1 ☐ Yes	2 No 3 Pro	obably 4 Unknown
e l					24a. Was an autopsy	24b. Were aut	topsy findings available ompletion of cause of
Š					performed?	'_ death?	
Be	25. Was case referred to medical examiner?		Tai.		h (Check only one)		
0			atient 3 DOA Othe	Nursing Ho	ome 5 Residence		eify)
<u></u>	1 Natural 5 Pending (Date of Injury 28b. Tim Month, Day, Year) Inju	ry Work		28d. Describe how in	jury occurred	
cat	2 Accident investigation 3 Suicide 6 Could not be			es 2□No			
ī	4 Homicide determined	Place of Injury - At home, farm ouilding, etc. (Specify)	, street, factory, office		28f. Location (Street City or Town, Sta	and Number or Ru ate)	ral Route Number,
ٽ آ	29a. Certifier Certifying Physician: T	o the best of my knowledge, o	leath occurred at the time	a date and slac-	and due to the server	v(e) and mar	stated
Medical Certification: To	(Check only 2 Medical Examiner: On t	o the best of my knowledge, o the basis of examination and/o manner stated.	or investigation, in my op	inion, death occur	red at the time, date a	nd place, and due	to the cause(s)
Me	29b. Signature and title of certifily		29c. License	number	29d. [Date signed (Month	, Day, Year)
						_	
	30. Name and address of person who completed	cause of death (Item 22a) (Ti-		7028		01-21-0) (
	Aditua Chopra M. D.			231 An	inapolis	MD3	1401
e .	A TOTAL CIOIS	32. Registrar's Signature	parks	Cot A	11 real (12	1-10 0	1701
r	JAN 2 2 2009	Cours B. "	barked				
21	Aut warned	The same of					

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DHMH 17 Rev 1/20

Stat Registra

			For State Registrar	State	of Marylar	-	artment of H			ntal Hyg	jiene	009	033	28
			Registrar 1. Decedent's Name (First, Middle, Last)							. Date of Dea	th		3. Time of	Death
	Physicia		Frenchie Odes	sa Richa	rdson					Month Jan. 1	7, Day		4:45	A^{M}
	/Medic Examin		4a. Facility Name (If not institution,				4b. City, Town, o	r Location				County of Dea		
		-	Manor Care -	Largo			Largo				P	rince (Georges	
T	Funeral			6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under Hours	24 Hrs. 8	. Date of Birth (Month, Day	Year)	9. Bir	thplace (State ountry)	or Foreign
	Director		367-24-5980	1□M 2 Q F	87	Yrs.	Working Days	110013	N	lov. 8,	192	21 Ge	orgia	
	pu:		Usual Residence of Decedent 10a. State 10b. County		100 0	ty, Town or Lo	cation						10d. Inside Ci	ity Limito
	aryla shov	አ	,										1 ☐ Yes	,
	he M 28a-f otifie	Director		Georges	up Up	per Mai	rlboro 10f. Zip Code			1.	0.00	zen of What Co		-X
	a or	ä	10e. Street and Number 12601 Whiteho	lm Drive	S		2077	74				S. A.	ountry?	
	be filed within 72 hours after death with the Maryland at Hygiene. And Hygiene. And chief than "natural", or items 23a or 28a-f show event, I'm Madiral Examiner must be notified at	Funeral			cedent Ever in L	18 13 1			rigin? (Speci	fy Vas or No-		14. Race - Ame	vican Indian	
_	ter d riter iner	표	11. Marital Status1 ☐ Never Married 2 ☐ Marrie	Armed F	orces? 2 1 No		Was Decedent of I If Yes, specify Cub	an, Mexicai	n, Puerto Ri	can, etc.)	'	Black, White		
2	ursal al", o	by	3 XWidowed 4 ☐ Divorced	If Yes, G Year or I	live	'	i⊡Yes 2⊠No	Specify.	:			Specify: Blā	ıck	
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<u>Va</u>		၉	Oscar Hughes					Cor	ca Sin	gleton				
ā	2 should be and Menta is marked aumatic ev		19a. Informant's Name/Relationshi Cora Watley -			19b. Mailir	ng Address <i>(Street</i> 1 Whiteho	and Numb	er or Rural i	Route Numbe	r, City or	Town, State,	Zip Code)	7.4
_	ges 1 and 2 should tt of Health and Mer I item 27 is marke or other traumatic			uaugiice										/ 4
altimore,	Pages 1 nent of 1- int: If ite iry or ot		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3	3 ☐ Removal from	i State I		sition (Name of natory or other pla		Dat		20c. Loc	cation - City or	Town, State	
=======================================	t. Pa rtmer rtant:		4 □ Donation 5 □ Other (Spe	-	Riv		ark Cremat		1/19/20			erdale,		
g R	permit. Pages Department of Important: If i any Injury or once.		21. Signature of Furreral Service L	gens / /	Com)	22	2. Name and Addre	ess of Facili	Bell	and Johr	isan 1	Funeral E	tome, P. J	A.
			23a. Part I Enter the disease, or o	ometions that	coursed the dea		5503 Old Bro					4D 20748	Approximate	
		s (1)	shock, or heart failure. List o	nly one cause on	each line.			ing, such as	s cardiac or	espiratory arr	est,		interval Bet Onset and I	ween
	Physician /Medical		disease or condition resulting in death)	a			Disease							
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Ř	death certifi e attending d for use as	an/l	23b. Was decedent pregnant		utcome of pregr		☐ Ectopic pregnan	cv			2	23d. Date of de		
	e dea the at red fo	sici	in the past 12 months? 1 ☐ Yes 2 ☒ No	4 ☐ Pre	gnant at time of		Other (specify)					Month	Day `	Year
Ţ.	w requires that the death certifi been signed by the attending should be detached for use as	Physician/M	9 ☐ Unknown Part II. Other significant condition	ne contributing to	dooth but not ro	aulting in the u	ndortuina aquaa air	on in Part I		23a Did to	hacco u	oo oontributo te	the cause of d	leath?
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_	n: The licate har, page									perfor 1 □ Yes	2 ⊠No	death? 1 □ Yes	2 □ No	
Vital	siciar certif ector	Be	25. Was case referred to medical examiner?	Hospital:			011	or:		Check only or				
	Phys this	<u>۲</u>	1 ☐ Yes 2 ☑ No 27. Manner of Death	1	Inpatient 2	28b. Time o	R 3 L DOA	42019				Other (Spe	ecify)	
ב	Attending Physician: r death. ector: After this certific by the funeral director,	ion	1 X Natural 5 ☐ Pending	(Mo	onth, Day, Year)	Injury	Wo	nyau rk?]Yes 2. □	- 1	d. Describe h	ow injury	occurred /		
Š	ofeat ctor: y the	fica	3 Suicide 6 Could no		ce of Injury - At h	ome, farm, str		1163 2	-	f. Location (S	treet and	d Number or R	ural Route Num	her
Division of	or A after Direction by	Certification:	4 ☐ Homicide determin	ied build	ding, etc. (Spec	ify)	eet, factory, office		20	City or Tow	n, State)	i Number of A	urar noute ivum	Der,
_	spita nours neral / filler		29a. Certifier 1 ☑ Certifying	Physician: To th	ne best of my kn	owledge, deat	h occurred at the t	ime, date a	ind place, ar	d due to the o	cause(s)	and manner a	s stated.	- 19
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	(Check only 2 Medical E	xaminer: On the	basis of examin nner stated.	ation and/or in	vestigation, in my	opinion, de	ath occurred	l at the time, o	late and	place, and due	e to the cause(s	i)
	To the within to the complete	Me	29b. Signature and title of certifier				29c. Licen					e signed (Mont		
			//www	A)			D5152	20			Janu	ary 17,	2009	
) 1		30. Name and address of person w	/ho completed car	use of death (Ite	m 23a) (Type,	Print)							
1			Bahram Pishda	d, M.D.	600 Lar	go Road	d, Largo,	_MD 2	20774					
	Sta		31. Date filed (Month, Day, Year)	Beneva 32.	Registrar's Sign	ature								
	Registr	ar	JAN 2 2 2009	cener	19									

			1 - For State Registrar	State of I	Maryland		artment of F <i>rtificate of</i>		and Me		gien Reg. N	(U U)	03329
	Physici		Decedent's Name (First, Middle, L CONSTANCE ALTH	·	IR					2. Date of De Month	Da	y Year 4 2009	3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution, g	ive street and number	er)		4b. City, Town, o			andary	40	: County of Dea	ath
8,12	Funeral Director		5. Social Security Number 6. 577–42–3103		Age (In yrs. la	as <i>t birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 2 Hours		B. Date of Bir (Month, Date ov • 21 ,	th	o Ri	nthplace (State or Foreign ountry) nington, D.C
	Maryland f show ied at	tor	Usual Residence of Decedent 10a. State 10b. County D • C •			Town or Lo						-	10d. Inside City Limits 1X Yes 2 No
	with the I 3a or 28a- st be notif	I Director	10e. Street and Number 1562 Kenilworth	Ave. N.E	•		10f. Zip Code 2001	9			-	tizen of What C	•
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ⑦ Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	s? X No		Nas Decedent of H f Yes, specify Cub	fispanic Orig an, Mexican Specify:	gin? (Speci	fy Yes or No ican, etc.))-	14. Race - Am Black, Whi	
21215-0036	within 72 hou ene. than "natura the Medical E	Completed	15. Decedent's (Specify only highest g	Education grade completed) College (1-4d	or 5+)	16a. Deced (Give life. I FOO	dent's Usual Occup kind of work done OO NOT use retired d Servic	pation during most d) e Prov	t of working vider		Į.	C. Gove	-
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lary	2 sholl and h		19a. Informant's Name/Relationship	(Type. Print)		19b. Mailir	g Address (Street	and Numbe	er or Rural	Route Numb	er, City	or Town, State,	Zip Code)
altimore, N	Pages 1 and ent of Health nt: If Item 27 ry or other to		Roland Keels / 20a. Method of Disposition Star Burial 2 Cremation 3 4 Donation 5 Other (Special Control of the Control of th			ace of Dispo	Southern sition (Name of natory or other place Memoria	ce)	N.E. Da 1/24/	te	20c. L	on, D.C. ocation - City of	Town, State
Balti	permit. Departm Importal any inju		21. Signature of Funeral Service Lice	9		22	Name and Addre 1 examde 5538 Mar Forestvi	ss of Facility	Pope	P.A.			
9,	Physician /Medical		23a. Part1. Enter the disease, or co shock, or heart fallure. List on Immediate Cause (Final disease or condition resulting in death)	ly one cause on each	n line.	Do not ent	er the mode of dyir			respiratory a	rrest,		Approximate Interval Between Onset and Death
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P.O. Box 687	ath certif ttending or use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown		n 2 ☐ Fetal t at time of de	death 3	Ectopic pregnanc	у		210		23d. Date of de Month	elivery Day Year
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n or Vital	Attending Physician: It death. ector; After this certific by the funeral director,	n: To Be	25. Was case referred to medical examiner? 1									acify)	
Division or Vital Records the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		Certification:	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	be 28e. Place of		ne, farm, str		Yes 2□ñ		f. Location (City or To	Street a wn, Stat	nd Number or R e)	tural Route Number,
	To the Hospital or Atter within 24 hours after dea To the Funeral Director completely filled in by the	edical	29a. Certifier 1	Physician: To the be aminer: On the basi and manner	s of examinati	/ledge, deatl on and/or in	n occurred at the ti vestigation, in my	me, date an opinion, dea	d place, an	d due to the	cause(s date ar	s) and manner a nd place, and du	s stated. e to the cause(s)
	To 1	Ψ	29b. Signature and title of certifier	_ S. S	iddex	uř	29c. Licens	67810				ate signed <i>(Mon</i> nuary 16	
1			30. Name and address of person what AMBREEN SIDDIQU	IE, MD. 30	001 Hos	pital		Chever	1y, M	D. 20	785		
	Sta Regist		31. Date filed (Month Day Year)	32. Reg	istrar's Signate	ure					-		

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year Physician Helen June Robertson 6:42 p M 16, 2009 January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Larkin Chase Nursing Home & Rehab. Bowie If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex Age (In yrs. last birthday) **Funeral** Months Days 1 ■ M 2 ★F Director 577-28-7287 June 10, 1920 Forestville, Md Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location or 28a-f show a notified at 10d. Inside City Limits Prince Georges 1 Yes 2 No Maryland Director Bowie 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? o e 3800 Enfield Chase Ct. 20716 United States Items 23a iner must b Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian "natural", or Items edical Examiner n Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Ho Specify: þ Specify: Black 3 Midowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) Educator P.G. County Schools the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked John Edward Hawkins Annie Littleton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i Karen A. Robertson / Daughter 42 Palmer Green Ct. Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages
Department of I
Important: If Ite
any Injury or o
once. 1 Burial 2 ☐ Cremation 3 ☐Removal from State 4 Donation 5 Other (Specify) Maryland Veterans 1/29/2009 Cheltenham, Md. 21. Signature of Funeral Service Li 22. Name and Address of Facility
Alexander S. Pope. P.A.
5538 Mariboro Pike Forestville, Md. 20747 23a. Part 1. Effect the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death **Physician** disease or condition resulting in death) 04 /Medical Examiner Sequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine law requires that the death certificate be executed physician and s the burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a Records, P.O. 9 Unknown conflibuting to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 NO 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page 2 autopsy performed certificate or Vital 1∐ Yes 2**/**2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of After t Certification: 28d. Describe how injury occurred Division or Attending 1 🔀 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital within 24 hours a

To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title 29d. Date signed (Month, Fay, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 6005 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Year SPRINGS 03:20 A M ANDERSON JANUARY 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Regional HUSPITAL LAUREL PRINCEGEDRGE Laurel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. May 24, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Months New York 578-42-7324 1**X** M 2□ F 75 Yrs Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ty∑Yes 2 ☐ No Maryland Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 900 Briarcroft Lane #347 20708 United States 14. Race - American Indian, Black, White, etc. African 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No In Nes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Specify: Specify: 3 Midowed 4 ☐ Divorced American 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 4 Vears Tax Auditor Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Thomas Springs Clara Reynolds 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Figural Floute Number, City or Town, State, Zip Code) Marie Singh Khela - Sister 7322 Florin Wood Sacramento, CA 95823 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veteran's Cemt Jan 29, 2009 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Sunature of Funeral Service Li-4001 Benning Road, NE Washington, DC 20019 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SE days disease or condition resulting in death) Due to (or as a consequence of): dons Sequentially list conditions, if any seeding of the data cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Year Month Day regnant at time of death 5 Other (specify) o death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 11 PE 1 ∐Yes 2 🔀 No 2 No 1 Yes 26. Place of Death (Check only one) Other Nursin

Physician /Medical Examiner Examine

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene... Important: if item 27 is marked other than any injury or other traumatic event, the Magnetic event, the Magnetic event, the Magnetic

Physician

/Medical

Examiner

Funeral

Director

28a-f shov

Director

Funeral

Completed by

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or than "natural", or items 23a or 28a-f show

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed attending physician a for use as the burialsigned by the a certificate has be irector, page 2 s after death.

I Director: Af
d in by the fur n 24 house. the Funeral Directory filled in

Physician/Medical

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Be Completed

Certification: To

Medical

Division of Vital Records, P.O. Box 68760,

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 □ Li 4 □ Pi 9 □ Ui
Part II. Other significant condition Revel 1 w.	
HYPERTENSION	
DIABUTES ME	=ZUTUS

HYPERTEN.	SION	0
DIABUTES	MELLITUS	TY
. Was case referred to me examiner? 1 ☐ Yes 2 X No	dical Hospital:	□Inpatien

examiner?		Но	spital: 1 🗆 li
27. Manner of Death 1 Natural	5 Pending	,	28a. Date (

th	
	5 Pending
	investigation
	6 ☐ Could not be
	determined

Service Co.	
Hospital: 1 ☐ Inpatient	2 KER/Outpatient
28a. Date of Injury (Month, Day, Yo	

nt 2 🔀	ER/Outpatient	3[
y , Year)	28b. Time of Injury	

' 1	☐ Inpatient	2 🔀	ER/Outpatient	3 ∐ [DOA	4	L
28a. Da (N	ate of Injury fonth, Day, Ye	ar)	28b. Time of Injury		28c.	Injury at Work?	
				M		1 □Yes	2
28e. Pla	ace of Injury - ilding, etc. (S	At ho	ome, farm, stree	t, facto	ry, of	fice	

	28c. Injury at Work? 1 □ Yes	2 🗆 No
to	ory, office	

gН	lome	5 🗌 Residence	6 ☐ Other (Specify)
	28d.	Describe how inju	ury occurred
	28f.	Location (Street a City or Town, Stat	and Number or Rural Route Number, te)

3	29a.	Certifie	ŀľ
		(Check	0
		one)	
L			

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

b. Signature and title of cert	ifier
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Sheep	M	D
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29c. License	number	
D	53	41

29d. Date signed (Month, Day, Year) Jan 15th 2009 14200 Laurel Park Dr.

State Registrar

Greater Laurel Health & Rehabilitation Center Laurel, MD 20707 J. Shesadri, MD 31. Date filed (Month, Day, Year) JAN 2 3 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

within 24 hor To the Fune completely fi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 15:35 M Simon Raisy D. 17,2009 January 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Takoma Park Washington Adventist Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number 1 □ M 2 1 F 249-62-1722 South Carolin 09/17/1936 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☐ No Washington DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20032 602 Galveston Place SE USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify. Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Supply Technician Gov't Printing Office 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Peter Johnson Gertrude Rivers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1748 19a. Informant's Name/Relationship (Type. Print) Keith J. Simon(Son) 3307 Huntley Square Drive #T1 Temple hillsMd 20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt.Olivet Cemetery 01-26-09 Washington, DC 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licent 22. Name and Address of Facility NW WashDC Tyrone J. Young 719 Kennedy St. er the disease, or co tion, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, calls on each line. 23a. Part1. Zn shock o Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) er6 Scherchic Due to (or as a consequence of): Se Sequentially list conditions, if any, reading to inimicanate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner

the death certificate be executed

P.O. Box 68760,

Division or Vital Records.

or Attending

Physician

/Medical

Examiner

Funeral

Director

a or 28a-f show be notified at

r than "natural", or Items 23a the Medical Examiner must b

Director

Funeral

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Completed

Be

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

s 1 and 2 should be fill Health and Mental H tem 27 Is marked oth

Pages 1 nent of ⊁

traumatic

Department of Health Important: If Item 27 any Injury or other to once.

Examine burial-tran attending physician for use as the burial Physician/Medical signed by the a 2 Completed certificate Be after death. Certification: the

24a. Was an autopsy performed's 26. Place of Death (Check only one) Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 1 Natural Injury

MO

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only one)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier

29c. License number 29d. Date signed (Month, Day, Year) 00060100

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 13400 Silva

Registrar

completely filled in by

Medical

within 24 hours a To the Funeral C Hospital

> Uniwasity 31. Date filed (Month) JAN 2 3 2009

32. Registrar's Si

State of Maryland / Department of Health and Mental Hygiene Of State Of Maryland / Department of Health and Mental Hygiene

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		•	- State Registrar				Cer	tificate c	of Death		Reg. No.	.000	
	Dhorisis		1. Decedent's Name		•					2. Date of D Month	eath Day	Year	3. Time of Death
	Physicia /Medic		Galen Ne	eil Smit	n					Janua	ry 12,	2009	8:05 А. м
	Examine	er	4a. Facility Name (If	not institution, gi	ve street and number)		:	4b. City, Town, or Location of Death 4c. County of Death					
1			THE JOHNS HOPKINS HOSPIT						nore				
ı	Funeral Director		5. Social Security Nu 555–76–2	658	Sex 7. Ag 1 □ XM 2 □ F	e (In yrs. last i	Yrs.	If Under 1 Ye Months Da			irth 9, Yea <i>r)</i> 9, 194	l Cou	place (State or Foreign intry) inois
	pur *		Usual Residence of 10a. State	Decedent 10b. County		10c. City, To	wn or Lo	cation					10d. Inside City Limits
	sho	5	MD	Montgon	erv	Germ							1⊠Yes 2□No
	the N	ect	10e. Street and Num		1			10f. Zip Cod			10a Citizo	n of What Cou	
	23a or	ra Di	12838 Re		rive			2	0874		Unite	ed Stat	•
9000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	d by Funeral Director	11. Marital Status 1 Never Marrie 3 Widowed		12. Was Decedent Armed Forces? 1 ☐ Yes 2★1 If Yes, Give Year or Dates:		i	Vas Decedent of Yes, specify C	of Hispanic Origin? (uban, Mexican, Puel No <i>Specify:</i>	Specify Yes or N rto Rican, etc.)		. Race - Amer Black, White, pecify: Whi	etc.
5-(72 h	etec	(Speci	15. Decedent's E	ducation ade completed)	16	a. Deced	lent's Usual Oc kind of work do	cupation ne durina most of wo	orkina	16b. Kind	of Business/Ir	ndustry
21215-0036	d within giene. rr than "	Completed	Elementary/Secon		College (1-4or 5	5+)		00 NOT use rei Eessor	ne during most of wo lired)		Educ	ation	
Marylan	should be filed and Mental Hygi s marked other umatic event, I	To Be C	17. Father's Name (Robert T							me (First, Middl n Hopk		ırname)	
	and 2 shore ealth and N n 27 is mare trauma		19a. Informant's Na Litse Sm						eet and Number or F re Drive,				· · · · ·
Baltimore,	of He of He item		20a. Method of Disp			20b. Place	of Dispo	sition (Name of	Jace) ; ty Jar	n. 15	20c. Loca	tion - City or T	own, State
Ĕ	permit. Pages Department of I Important: If ite any Injury or of			JCremation 3 L 5 □Other <i>(Spec</i>	Removal from State	Geo. Medi	wasi	natory ar other of 1. University Center	ersity 200		Washi	ngton,	D.C.
ati	permit. Departr Importa any Inju		21. Signature of Fur	negal Service Lice	nsee		22	. Name and Ad	dress of Facilit	lumbia M	ortuar	y Serv	ices,P.A.
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	Physician /Medical Examiner	Je.	shock, or hear Immediate Cause (i disease or condition resulting in death)	t failure. List only Final 1	b. Mes	a consequence	e of):	Fa		ac or respiratory	arrest,	ar	Approximate Interval Between Onset and Death Uay S
و8760, حم	ate be executed hysician and he burial-transit	cal Examiner	Sequentially list con if any, leading to imr cause. Enter Under Cause (Disease or i that initiated events resulting in death) L		c	a consequenc	equence of):						
O. Box	requires that the death certificate be executed seen signed by the attending physician and nould be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 ☐ Fetal dea		Ectopic pregnation of the control of			230	d. Date of deli	very Day Year
σ,	s that ned t	by Pr	Part II. Other signifi	cant conditions	contributing to death b	ut not resulting	in the ur	nderlying cause	given in Part I.	23e. Did	I tobacco use	contribute to	the cause of death?
rg	w requires t s been signe should be o	g p								1 🗆	Yes 2 🔀	No 3□ Pro	bably 4 Unknown
Vital Records,	The law ate has b page 2 sl	Completed								24a. Wa aut per 1 □ Yes	s an opsy formed?	24b. Were aut prior to co death? 1 ☐ Yes	opsy findings available ompletion of cause of 2 □No
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of.	Physician: this certific ral director,		1 Yes 2 文		Hospital: 1 🔀 Inpati			0 0001		Home 5 ☐ Re			ify)
Division of	Attending F r death. ector: After by the funer	ation:	27. Manner of Death 1 Manner of Death 2 Natural 2 Accident	5 Pending investigation			. Time of Injury	V	njury at Vork? □Yes 2□No	28d. Describe	e how injury o	occurred	
Divis	al or Atte	Certification: To	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	28e. Place of in	ury - At home, c. (Specify)	farm, str	eet, factory, office	ce	28f. Location City or To	(Street and I own, State)	Vumber or Rui	al Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical C			thysician: To the best iminer: On the basis of and manner st	of examination							
	To th To th comp	Me	29b. Signature and	title of certifier					ense nu m ber		29d. Date s	signed (Month	, Day, Year)
	10		X	9	- medi	ca10=	octo,	RS	55-00	0	Janua	21421	2009
			30. Name and addre	ess of person who	completed cause of o	death (Item 23	a) (Type,	Print)					
			Rana Yel	SiC To	32 MET &	Limale	0.5		1-0 000	0100.		0000	

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Samuel J. Steinberg January 20, 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Bethesda Health and Rehabilitation Bethesda Montgomery 7. Age (In yrs. last birthday) If Under 1 Year | if Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Days Hours 1**⊠**M 2□F 578-36-5488 79 March 11, 1929 Washington, DC Usuet Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1K Yes 2 No Be Completed by Funeral Director Montgomery Bethesda 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6701 Kenhill Road 20817 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ⊠Yes 2 □ No 1955— ff Yes, Give Year or Dates: 1957 1 Never Married 2 Marned White 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usuaf Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Efementary/Secondary (0-12) Colfege (1-4or 5+) 5+ Dentistry Dentist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Steinberg Lilly Stein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet L. Steinberg, wife 6701 Kenhill Road, Bethesda, Maryland 20817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition tX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Garden of Remembrance 01/22/2009 Clarksburg, Maryland 22 Name and Address of Facility
Edward Sagel Funeral Direction, Inc. 21. Signature of Funeral Service Donald 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part1. Enter the disease, or complications that caused be death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final VUSTATU Metastatic Unknown disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown

Physician /Medical **Examiner**

Funeral

Director

if Health and Mental Hygiene. Item 27 is marked other than "natural", or itema 23s or 28e-f show other traumatic avent, the Medical Examinat must be notified at

permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: If Item 27 is marked other any injury or other traumatic avant, pones.

death with the Maryland

Baltimore, Maryland 21215-0036

burial-transit and attending physician use as the signed by the atter signed by pluods page 2 s certificete has funeral director Sign

The law requires that the death certificate be executed

or Attending

To the Hospite

within 24 hours after death. To the Funeral Director: A

the

filled in by

completely

Division of Vital Records, P.O. Box 68760.

Be Completed by

23e. Did tobacco use contribute to the cause of death?

Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. monia

24a. Was an 1 ☐ Yes

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

1 Yes 2 No 3 Probably 4 Unknown

25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death 1 Natural

5 Pending investigation 6 Could not be determined

Hospital: 1 | Inpatient 28a. Date of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA 28b. Time of Injury

Other: 4 Nursing Home 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

autopsy perform rmed? 2 X No

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and title of certifier

2 Accident

4 Homicide

3 Suicide

29a. Certifier

29c. License number

29d. Date signed (Month, Day, Year)

howth

28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify)

30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) DINO DRIVE; BURTONSVILLE, MO 20866 MD; 15216 NURUL CHOWDHURY

State Registrar

ical Certification: To

31. Date fifed (Month, Day, Year) 32. Registrar's Signature 22

DHMH 17 Rev 1/2001

			For State Registrar	State	of Marylan		ertment of H				9	03335
			1. Decedent's Name (First, Middle	, Last)					2. Date of Deat	th		3. Time of Death
	Physicia			Larry B.	Solomon				Month January	Day 21	Year 2009	5:10am
Co. Market	/Medic		4a. Facility Name (If not institution				4b. City, Town, or Location of Death			4c. County		<u></u>
	ZAGIIIII		Casey	House				Rockville	5		Monf	tgomery
	Funeral		Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	16	9. Birthp	lace (State or Foreign
	Director		212-38-4032	1⊠M 2□F	67	Yrs.	Months Days	Hours Min.	(Month, Day,		Coun	New York
p			Usual Residence of Decedent						1 2			
rylar	w H	_	10a. State 10b. County		10c. Cit	y, Town or Lo	cation				1	0d. Inside City Limits
e Ma	Ba-f	50	Maryland Mon	tgomery			01	lney				1 □Yes 2 ☑ No
iff th	or 28	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen of W	/hat Coun	itry?
G ZIZI3-UU30 filed within 72 hours after death with the Maryland	23a	<u>ra</u>	18212 Allwo	od Terrace				20832			U.S	S.A.
r dea	ems	Funeral	11. Marital Status	12. Was Ded Armed F	cedent Ever in U. orces?	S. 13. \	Vas Decedent of His f Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No- Rican, etc.)		e - Americ k, White, e	an Indian,
30 afte	9	by F	1 ☐ Never Married 2 ☑ Marr	If Yes, G			□Yes 2⊠No	Specify:		Specify:		
5-UUSD 72 hours aff	[La]		3 ☐ Widowed 4 ☐ Divorced	Year or I	Dates:						I	White
72	"nat	Completed	15. Decedent (Specify only highes	s Education t grade completed)	(Give	lent's Usual Occupa kind of work done d	uring most of work	king	16b. Kind of Bu	siness/Inc	dustry
vithir Z	than	直	Elementary/Secondary (0-12)	College	(1-4or 5+)	ille. L	OO NOT use retired) Deputy Di		1,	National I		Corrections
lled A	ther int,		17. Father's Name (First, Middle,	astl	5+		<u> </u>	18. Mother's Nam				ute or
and d be file	ental ed o	Be c	,	·				TO. MOUTET S TEATH	,		,	
Joint Z	nark matir	은	Harry Solom 19a. Informant's Name/Relationsl			10b Mailin	g Address (Street a	and Number or Du		an Solomoi		0-4-)
M Z S	than 7isi trau											Coae)
a, -	Heal em 2 ither		Dena S. Solo 20a. Method of Disposition	mon - Wife	20h F		3212 Allwood			ry1and 208 20c. Location - 0		wn State
ages	Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified all once.		1 ☑ Burial 2 ☐ Cremation		1 State		sition (Name of natory or other place	i .			,	·
artimo	rtme rtani njun	11.5	4 □ Donation 5 □ Other (S)		Jude		rial Garden . Name and Addres		5/2009	Olne	y, Ma	ryland
per Da	Depa Impo any Ir		21. Signature of Funeral Service	Down	000	Hi	.nes-Rinaldi	Funeral H				
	_		23a Part 1 Enter the disease or	complications that	caused the deat		800 New Han				, Mary	
		8 3	23a. Part 1. Enter the disease, or shock, or heart failure. Live Immediate Cause (Final	only one cause on	each line.	n. Do not one	or the mode or dying	g, sacri as caraiac	or respiratory arr	631,	- 12	Approximate Interval Between Onset and Death
	ysician Medical		disease or condition resulting in death)	_ a	Sarcoidosi							
	aminer		g ,	Due to	(or as a conseq	uence of):						
		ᡖ	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of):									
rted	nsit	듩	cause. Enter Underlying Cause (Disease of Might) that initiated events c.									
exect	n and al-tra	Examiner	that initiated events resulting in death) Last	c Due to	o (or as a consequence of):						-	
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ath cert	use a	sician/Me	IF FEMALE: 23b. Was decedent pregnant		utcome of pregna					23d, Date	e of delive	erv
death a	e atte	icia	in the past 12 months? 1 □Yes 2 □No	4 ☐ Pre	birth 2□Feta gnant at time of d		Ectopic pregnancy Other (specify)			Mor		Day Year
g e	by the	hys	9 Unknown	9 □ Unk	nown							
that	ned b deta	by P	Part II. Other significant condition	ns contributing to	ntributing to death but not resulting in the underlying cause given in Part I.				23e. Did tol	bacco use contri	ibute to th	ne cause of death?
Hecords, he law requires t	n sig lid be								1 □ Ye	es 2 🗆 No	3∏ Prob	ably 4 🕅 Unknown
S §	s bee	Completed							24a. Was a	n 24b. V	Vere auto	psy findings available
Pe a	e has	Ĕ							autops perforr	ned? p	rior to cor leath?	npletion of cause of
VITAI iclan: ⊺	iificat or, pa	ပိ	25. Was case referred to medical					00 Division (Division	1 □Yes	2 ⊠ No 1	□Yes	2 □No
Sicle	s cert	100	examiner? 1 ☐ Yes 2 ☒ No	Hospital:	Inpatient 2	EB/Outnotion	Othe	26. Place of Deat				. 11
P F	ar this	1: To	27. Manner of Death	28a. Date	of Injury	28b. Time of	28c. Injury Work	er: 4 Nursing Ho	28d. Describe ho			y) Hospice
UIVISION I or Attending	th.	ţ	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investig		nth, Day, Year)	Injury		? ⁄es 2 □No		,,		
Atter A	r dea octor	fica	3 ☐ Suicide 6 ☐ Could r	ot be 28e. Plac	e of Injury - At ho	l ome, farm, stre	eet, factory, office		28f. Location (St	reet and Numbe	er or Rura	l Route Number.
בַּ ב	Dire	Certification:	4 ☐ Homicide determ	build	ding, etc. (Specif	fy)			City or Town	n, State)		
spita	hours Inera y fille		29a. Certifier 1 Certifyin	g Physician: To th	e best of my kno	wledge, death	occurred at the tim	ne, date and place	, and due to the c	ause(s) and ma	nner as s	tated.
he Ho	within 24 hours atter death. To the Funeral Director. After this certificate has been signed by the attending i completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only 2 ☐ Medical one)	Examiner: On the	basis of examina nner stated.	ation and/or in	vestigation, in my op	oinion, death occur	rred at the time, d	ate and place, a	ind due to	the cause(s)
10 tt	To #	Me	29b. Signature and title of certifier		P		29c. License	number	2	9d. Date signed	(Month,	Day, Year)
			Joselyne	Loucet	theu	mD	200	63 748		Januar	y 21.	2009
1	>		30. Name and address of person	who completed cau	use of death (Iten	n 23a) (Type,	Print)					
			Jocelyne Kouatc			, , , , ,	,	Baltimore	, Marvland	1 21218		
	Sta	ite	31. Date filed (Month, Day, Year)	22.	Registrar's Signa	ture	control of		, , ,			
	Registr	ar	JAN 22 2	UU9 Den	un B.	par						
				/	-	1 1						

Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760

Division or Vital Records, P.O. Box 68760

State Registrar 29b. Signature and title of certific

31. Date filed (Month.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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F	Examin uneral irector	ner	4a. Facility Name (If not institution, MORECE 5 5. Social Security Number 275–20–9364	ASSISTED	e (In yrs.	ING ast birthday) Yrs.		A POLL S If Under 24 Hrs. Hours Min.	>	irth Year	c. County of Deat	ARUNDAL thplace (State or Foreign buntry)
P			Usual Residence of Decedent		T				7/9/1	720		
Maryta	-f show	tor	Maryland Montgor	no ru		y, Town or Lo $kville$						10d. Inside City Limits 1 ☑ Yes 2 ☐ No
ith the	or 28a	Funeral Director	10e. Street and Number			10,12220	10f. Zip Code			10g. Citizen of What Country?		
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Maryland 21215-0036 to 2 should be filed within 72 hours after death with the Maryland	Department of meant and mental riggers. In inportant if it is made at 19 and 19	by	11. Marital Status 1 □ Never Married 2 ☑ Marrie 3 □ Widowed 4 □ Divorced	Armed Forces?		T	was becedent of r If Yes, specify Cuba 1 □ Yes 2 □ No	dispanic Origin? (Span, Mexican, Puerto Specify:	Rican, etc.)	0-	14. Race - Ame Black, White Specify: Whi	e, etc.
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ld be	ked c	To B	Charles Schirm	er				Margare	et Lan	O	,	
ary shou	s mar	-	19a, Informant's Name/Relationshi	p (Type. Print)		19b. Mailir	ng Address (Street	and Number or Ru			or Town, State, 2	Zip Code)
and 2	m 27 her tra		Maria O. Schirm	er/Wife		12801	Leahy D	rive Rock				
altimore, rmit. Pages 1 ar	or ot		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3				sition (Name of natory or other place		Date		Location - City or	•
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/M	sician edical		23a. Part 1. Inter the diseas , or c shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	nly one cause on each li	ne. MON	Do not ent			or respiratory	arrest,	pe	Approximate Interval Between Onset and Death
cecuted	sician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c									
. Box 68760	attending phy for use as the	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	Due to (or as d. 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	of pregna	incy	Ectopic pregnanc	у			23d. Date of del Month	ivery Day Year
P.O	ed by t detach		9 ☐ Unknown Part II. Other significant condition	s contributing to death b	ut not resu	ulting in the u	nderlying cause giv	en in Part I.	23e, Did	tobacco	use contribute to	the cause of death?
Vital Records, sician: The law requires t	been signed by the should be detached	Completed by	DOPROSSION	/					- 11			obably 4 🗆 Unknown
eco law re	2 CV	plet	ATAXIA						24a. Was	an nev	24b. Were au	topsy findings available completion of cause of
— ₽	certificate has ector, page 2 s	Com	CORONARY.	ARTERY	1025	01455	2		perf	opsy ormed? 2	death?	2 □No
Vita sician	certifi	Be	25. Was case referred to medical examiner?	Hospital:			_ Oth	26. Place of Dear				45575KPD
E 5	After this funeral di	tion: To	1 Yes 2 No 27. Manner Death 1 Natural 5 Pending 2 Accident investiga	28a. Date of Inju	irv	ER/Outpatier 28b. Time of Injury	28c. Injur Worl	4 LI Nuising In	ome 5 ☐ Res 28d. Describe		6-Other (Specury occurred	city) Li VINCO
Division To the Hospital or Attending within 24 hours after death.	To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification: To	3 Suicide 6 Could no determin	t be ed 28e. Place of Inj building, et	ury - At ho c. (Specif	me, farm, str	eet, factory, office		28f. Location City or To	(Street a wn, Sta	and Number or Ru te)	iral Route Number,
e Hospi	e Funer letely fil	Medical	29a. Certifier (Check only one) Certifying 2 Medical E	Physician: To the best kaminer: On the basis of and manner st	f examina	wledge, deat tion and/or in	n occurred at the til vestigation, in my o	me, date and place opinion, death occu	, and due to the rred at the time	e cause(, date ar	(s) and manner as nd place, and due	s stated. to the cause(s)
To th	To th comp	Me	29b. Signature and title of certifier	J. L.	lu	my	29c. Licens	e number 46360)	29d. D	ate signed (Month	n, Day, Year) 19. 2039
		ļ	30. Name and address of person w	ho completed cause of d	eath (Item	23a) (Type,	Print)	Here	w vA		2010	11071108
	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 1 2	32/Registr	ar's Signa	ture	Med Med	11161+111	94 [V]]	LLE	ies in Le	- W C/100

DHMH 17 Rev 1/2001

Baltimore. Maryland 21215-0036

1	Physician
	/Medical
	Examiner
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Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely tilled in by the funeral director, page 2 should be detached for use as the burial-transit
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		Please	•								
		For	State of Ma	aryland	l / Depa	artment of	Health and	Mental H	/giene	Pnns	03339
		State Registrar			Cei	rtificate of	f Death		Reg. No.	_003	
Physici	an	Decedent's Name (First, Middle, Last	st)					2. Date of D _Month		Year	3. Time of Death
/Medic	al	Karen B. Smith						Janua		2009	9:00 pм
Examin	er	4a. Facility Name (If not institution, give)			, or Location of Dea	ath	4c.	County of Deal	
		2 Chinaberry Lane 5. Social Security Number 6. S		je (in yrs. las	st hirthday)	Indian If Under 1 Yea		S. 8 Date of R	rth	Charles	thplace (State or Foreign
Funeral Director			□ M oVZ r	9	Yrs.	Months Day			ay, Year)	Co	Florida
		Usual Residence of Decedent	1					pept.	10,	1949	rioriua
ylanc how		10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
a-fs	cto	Maryland Charles		Inc	dian H	:lead					1 Kartes 2 No
if th	Director	10e. Street and Number				10f. Zip Code)		10g. Citi	zen of What Co	ountry?
ath w		2 Chinaberry Lane	T			206				.S.A.	
er de	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		. 13. \	Was Decedent of If Yes, specify Cu	f Hispanic Origin? (uban, Me xican, Pue	(Specify Yes or N erto Rican, etc.)	0-	 Race - Ame Black, White 	
rs aft	by F	1 ☐ Never Married 2 ☐XMarried 3 ☐ Widowed 4 ☐ Divorced	1 □Yes 2 🔯1 If Yes, Give Year or Dates:	NO		1 □Yes 2 X N	o Specify:			Specify:Whi	te
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al Hy lothe	Be	17. Father's Name (First, Middle, Last)					18. Mother's Na	ame (First, Middle	e, Maiden	Surname)	
Ment Ment arked	၉	Franklin Eugene	Branham				Joan	McCarth	ıy		
2 sho and is m		19a. Informant's Name/Relationship (et and Number or I				,
and lealth m 27		Michael J. Smith	HUsband		2 Chi	naberry	Lane, In	dian Hea			
ges 1 it of F if ite or ot		20a. Method of Disposition 1 ☐ Burial 2 🌠 Cremation 3 ☐	Removal from State	20b. Pla	ace of Dispo metery, cren	sition (Name of natory or other pi	Jan. 2	21, 2009		cation - City or	
t. Pa tmen tant:		4 ☐ Donation 5 ☐ Other (Specification)	y)	Metr	coborr	.can rune	erai Serv	rice		xandria	, Virginia
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I file of 71 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lice		00660	22 W	2. Name and Add /illiams	fress of Facility Funeral	Home, P.	Α.		
10200		23a. Part 1. Enter the disease, or com	M	00668							20540
			plications that course	d the death	Do not ont	270 Hawt	thorne Rd	., India	n He	ad, Md.	20640
		shock, or heart allure. List only	one cause on each lii	d the death.	Do not ent	270 Hawt ter the mode of d	thorne Rd lying, such as cardi	l., India ac or respiratory	n He arrest,	ad, Md.	Onset and Death
Physician /Medical	2:	shock, or heart ailure. List only Immediate Cause (Final disease or condition resulting in death)	a. META	d the death. ine.	Do not ent	270 Hawt ter the mode of d	thorne Rd lying, such as cardi	l., India ac or respiratory	n He arrest,	ad, Md.	interval Between
Physician /Medical Examiner	7.	shock, or hear allure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each lii	d the death. ine.	Do not ent	270 Hawt ter the mode of d	thorne Rd lying, such as cardi	l., India ac or respiratory	n He arrest,	ad, Md.	Onset and Death
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ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2:07 M 200 /Medical 20 Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NICIMIC REGIONAL SAL1364R LOKAL If Under 1 Year Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State on Foreign **Funeral** Months Year) 1 M 2 F Days Hours Min. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, I'm Modical Experiment out the notified at once. 10b. County 1.0c. City, Town or Location 10d. Inside City Limits Be Completed by Funeral Director 1 Pres 2 No 10f. Zip Code Street and Numbe 10g. Citizen of What Country? Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2☐No If Yes, Give Maryland 21215-0036 1 ☐Yes 2☐No Specify: 3 Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Father's Name (First, Middle, Last) Name (First, Middle, Majden ၉ 9a. Informant's Name/Relationship (Type. Print) Rural Route Number, City or Town, State, Zip Code) daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Name and Address of Facility 21801 Bennin Snith Fundal Homes 917 W. Isabella St. Salisbury ma 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** RSA 0 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner veumon. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi UTI and Due to (or as a consequence of): P.O. Box 68760. physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month 5 ☐ Other (specify) 1∐Yes 2⊠No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown To the Funeral Director: After this certificate has been s completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy after death.

Director: After this certificate 2 No 2 No 1 ☐Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

rernando

31. Date filed (Month, Day, Year)

arrollst.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PRMC

Redistrar's Signature

2009 03341

eath-300 - 65		Registrar Certificate Of	Death	Reg. No.						
Physici edical Exami		1. Decedent's Name (First, Middle,Last) Terry Anthony Stone		2. Date of Death Month Day Year January 29, 2009	3. Time of Death 1654 hrs					
		4a. Facility Name (if not institution, give street and number) 4422 Landing Way	b. City, Town, or Location of Death Landover Hills	4c. County of Death Prince George						
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 230-08-3086 X M 2 F 39 Yrs.	If Under 1 Year If Under 24Hrs Months Days Hours Min	To and a	hplace (State or n untry) Alabama					
any	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside								
Aaryland 28a-f show 1 at once.	Director	Maryland Anne Arundel Glen Burn 10e. Street and Number	ie 10f. Zip Code	10g. Citizen of What Cour	1 Yes 2 X No					
ith the Ma 23a or 28 notified		415 S. Hidden Brooks 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was	21061 Decedent of Hispanic Origin? (S	U.S.A.	can Indian, Black,					
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mernal Hygie with min. If filed 27 is marked other than "matural", or items 23a or 28a-f she mit. If filed 27 is anaked other than "matural", or items 23a or 28a-f she more traumatic event, the Medical Examiner must be notified at once	by Funeral	1 Never Married 2 Married Armed Forces? If Yes 2 No If Yes 2 No If Yes 2 No If Yes 2 No If Yes 2 No If Yes 2 No If Yes 2 No If Yes 1 No If Yes 1 No If Yes 1 No If Yes 1 No If Yes 1 No If Yes 2 No If Yes 1 No If	es, specify Cuban, Mexican, Puerto Yes $2 \overline{X}$ No specify:	Rican, etc.) White, etc. Specify: Bla	ck					
6 172 hours: an "naturi cal Exami	eted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	's Usual Occupation (Give kind of ost of working life. DO NOT use ret		ndustry					
21215-0036 uld be filed within 73 Mental Hygiene marked other than c event, the Medical	Compl	17.1 date o Marie (1 not, mode) 2001,	18.Mother's Nam	e (First, Middle, Maiden Surname)						
D 21215-00% should be filed within and Mental Hygiene 7 is marked other that event, the Med	T. Be		Address (Street and Number or	Rural Route Number, City or Town, State						
Baltimore, MD 2 permit. Pages 1 and 2 shou Department of Health and N Important: If item 27 is n injury or other traumatic			tion (Name of cemetery,	Hill, Alabama 368 Date 20c. Location - City or	Town, State					
Baltimore, permit. Pages Lan Department of Hea Important: If ite		4 Donation 5 Other Specify: New Hope 21. Signature of Funeral Service Licensee 22. N	ame and Address of Facility	-4-09 Camp Hill czullo Funeral C	hapel, P.A.					
Physician	-	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.	009Harford Roa	ad,Baltimore,Mar	yland21214 Approximate Interval Between Onset and					
/Medical xaminer		Immediate Cause (Final disease or condition resulting in death) a. Contact Gunshot Wound of Head Due to (or as a consequence of):			Death					
	aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated sents routhins in death). Let								
executed in and il - transit	\ <u>@</u>	events resulting in death) Last								
x 68760, h certificate be execute tending physician and use as the burial - tran	⊨	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fe 4 Pregnant at time of death 5 Ott	tal death 3 Ectopic pregr	23d. Date of deliver Month	y Day Y ear					
, P.O. Box 6 res that the death ce signed by the attendible detached for use	by Physici		inderlying cause given in Part I.	23e. Did tobacco use contribute to						
cords law requi has been 2 should	plete		-	24a. Was an 24b. Were au	utopsy findings available completion of cause of					
of Vital Recoing Physician: The law After this certificate has	o Be C	25. Was case referred to medical examiner? Hospital: 1 Innation: 2 ER/Outnation	26.Place of Death (Check 3 DOA Other Nurs	conly one) ing Home 5 Residence 6 ✔ Othe	r: Scene					
on of Vir nding Physiath. rr. After this	tion: To	27 Manner of Death 28a Date of Injury 28b. Time of I	njury 28c. Injury at Work? 1 Yes 2 ✓ No	28d. Describe how injury occurred Subject shot self						
Divisical print of the state of	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined Specify Woods	et, factory, office building, etc.	28f. Location (Street and Number or Re or Town, State) 6422 Landing Way , , Md	ural Route Number, City					
Division To the Hospital or Attency within 24 hours after death To the Funeral Director: completely filled in by the	Medical C		rred at the time, date and place, ar tion, in my opinion, death occurred	d due to the cause(s) and manner as sta at the time, date and place, and due to the	ted. ne cause(s)					
F 3 F 3	Me	29b. Signature and title of certifier Melhouse Melhol	29c. License number O.C.M.E.	29d. Date signed (Mo January 31, 200						
		30. Name and address of person who completed cause of death (Item 23a)	enn Street, Baltimore, MD	21201						
	State	31. Date filed (Neonth Pay Year) 100 32 Registrar's Signature	V. 8							

<i>y</i> 1.						0.0	701
State of	f Maryla	nd / Depa	rtment of H	lealth and	Mental Hy	giene U	U:

		_	For State Registrar	State of Maryland		tificate of D		F	Rag. No.	005	00012
	Physicia	an	1. Decedent's Name (First, Middle, Last)		_			2. Date of Dea Month Janua:	Day	5 2009	3. Time of Death
	/Medic Examin		Geraldine Beat 4a. Fecility Name (If not institution, give	street and number)		4b. City, Town, or L		vanua	4c. C	County of Death	
			St Thomas Moore			Hyattsv			Pr	ince G	eorge's
	Funeral Director		5. Social Security Number 577-48-2102 6. Security Number 1	7. Age (In yrs. la	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day April	1 9 1	9 22 DC	place (State or Foreign ntry)
	yland now		10a. State 10b. County		, Town or Loc					1	0d. Inside City Limits
	e Man 3e-f sh	ctor	DC	Was	shing						1XYes 2 No
	th with th	ai Dìre	10e. Street and Number 2424 Elvans Rd	# 104		10f. Zip Code 20020		Ţ	J.S.	en of What Cou	ntry?
21215-0036	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene important: if Item 27 is marked other than "natural", or iteme 23a or 28a-f show aimportant: if Item 27 is marked other than "natural", or iteme 23a or 28a-f show aimportant in item 23a or 28a-f show any injury or other treumstic svent, the Medical Examination and once.	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		/as Decedent of Hisp Yes, specify Cuban, ☐ Yes 2X No	panic Origin? (Spe Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		4. Race - Americ Black, White, Specify: B1	etc.
5-0	72 hc "natur	eted	15. Decedent's Edu (Specify only highest grad		(Give k	ent's Usual Occupati and of work done du	on ring most of work	ing	16b. Kind	d of Business/In	dustry
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ם 2	al Hygi other	Be Co	17. Father's Name (First, Middle, Last)		Day	1	8. Mother's Name		Maiden S		
ylar	should be ind Mental marked o	To	William Green				Maud Ha				
, Maryland	alth and 2 sh		19a. Informant's Name/Relationship (Ty Cecelia Randolp	h Forrest	5604	Helmont	Pl Oxc	on Hill	r, City or L Md	70wn, State, Zip 2074	_
Baltimore,	Pages 1 en nent of Heal int: if Item 2 iry or other		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	lemoval from State Har	ace of Dispos metery, crem mony	ition <i>(Name of</i> atory or other place) Memorial	4/00	/2009		ation - City or To lover 1	
Balti	permit. Page Department important: if any injury or once.		21. Signature of Funeral Service Licens	Burna		Name and Address				Funera gton D	
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the death. ne cause on each line.			1				Approximate Interval Between Onset and Death
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	79 ##	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (one s a consequ		. 1					
	secute end al-trans	Examiner	that initiated events resulting in death) Last	Due to (or as a consequence	ence of):	Mellin	ris		-		
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s, P.	The taw requires that the nee been signed by the base been signed by the bage 2 should be detached.	by Ph	Part II. Other significant conditions con	ntributing to death but not resu	Iting in the un	derlying cause given	in Part I.	23e. Did to	bacco us	e contribute to t	ne cause of death?
ords	w require been sig should b		Forture To	THRIVE				1 🗆 Y	es 2 🗆	No 3□Prot	ably 4 \Unknown
Vital Record	e taw re has be je 2 sh	Completed						24a. Was autop	sy	prior to co	psy findings available mpletion of cause of
al B	w							1 Yes	2X No	death? 1 ☐ Yes	2 □ No
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n of	ng Phy ter thi		27. Manner of Death 1 ∑ Natural 5 ☐ Pending		28b. Time of Injury	28c. Injury a Work?	ıt T	28d. Describe h			7/
siol	Attending r death. ector: After by the fune	catic	2 Accident investigation 3 Suicide 6 Could not be			M 1 ☐ Ye	s 2 No	006 1 10 10	·	M. mbara O.	10
Division	el or At s efter o	Certification:	4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, stre	et, factory, office		City or Tow		Number or Hura	il Route Number,
	To the Hospitel or Attending Ph within 24 hours efter death. To the Funerel Director: After thi completely filled in by the funeral.	edicai (29a. Certifier (Check only one)	sician: To the best of my know ner: On the basis of examinati and manner stated.	vledge, death ion and/or inv	occurred at the time estigation, in my opin	, date and place, nion, death occurr	and due to the d red at the time, d	ause(s) a	and manner as s place, and due to	tated. o the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	to more)	29c. License r				signed (Month,	
			en	way, roll		MO	21524	P	- 1	1210	7
7	2		30. Name and address of person who co		23a) (Type, F	Print)	enum s	T. NE	#01	or wil	9 DC 20017
	> Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signat		1100 0 801		J: , U	-1-	0 (**

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician**) EROME THOMAS 0935 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital L Takoma
If Under 1 Year | If Under MONTGOMERY Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1√2 M 2□ F Months Days Hours Director 58 219-54-5722 Mar.31,1950 Wash. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Exeminar many harmed. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tyes 2 □ No MD Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? 555 Thayer Ave. #408 20910 Completed by Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 □No Specify: 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) llth Self-employed Carpenter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Thomas ည Allene Crutchfield 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 601 E. Randolph Rd, #T-5,Silver Spring,MD Allene Thomas (Mother) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory 1/24/09 Hanover, MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 23a. Part1. Enter the disease, of complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 246 N. Washington St. Rockville, MD 20850 Immediate Cause (Final disease or condition resulting in death) Preumena **Physician** /Medical Due to (or as a consequence of): Examiner Imenary Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe Division of Vital 2 NO 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Salyuscul Ven, MD D0063783 01/13/09 7600 CARROLL AVENUE TAKOMA BALL, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SABYASACH UMC 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

			1 - For Amend Item Registrar	s State of Marylar 28a-28f per	nd / Depa me, 888	artment 18 02/1 Tincate	of Health and 3/09dhh of Death	Mental Hy	giene Reg. Ne.	009	033	44
	Dhysisi		1. Decedent's Name (First, Middle, Las	st)				2. Date of Dea	ath Day	Year	3. Time of	
	Physici /Medic		Orval Lawrence '	Teets				January	y 20,	2009	4:35	5 P ^M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, To	wn, or Location of Dea	th	4c. C	ounty of Dea	th	
	Funeral Director		5. Social Security Number 6. S 710-09-7366	Memorial Hospi 7. Age (In yrs. M 2 F 87	tal last birthday) Yrs.	Oakl If Under 1 Months (h y, Year)	Co	thplace (State of ountry)	r Foreign
	iand iand		10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation					10d. Inside Ci	ty Limits
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	r 28a	rec	10e. Street and Number			10f. Zip C	ode		10g. Citize	on of What Co	ountry?	
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36	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. It and Mental Hygiene. If Is marked other then "naturel", or iteme 23e or 28e-f ehow treumatic event, the Madical Examinar must be mailined at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in L Armed Forces? 1 17 Yes 2 □ No If Yes, Give Year or Dates:1944-		Was Deceder If Yes, specify 1 ☐ Yes 2	nt of Hispanic Origin? (S Cuban, Mexican, Puel No Specify:	Specify Yes or No no Rican, etc.)		I. Race - Ame Black, Whit Specify: W	te, etc.	
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Maryland	ind 2 shore alth and h		19a. Informant's Name/Relationship (1	-	Street and Number or R					
Baltimore,	ges 1 and of Healing 1 if item 2 or other		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐		Place of Dispo cemetery, crea	osition (Name matory or othe	of er place)	Date	20c. Loca	ation - City or	Town, State	
Ë	nit. Pag artment ortant: injury c		4 □ Donation 5 □ Other (Specify) Gar			Gard. Jan					
Bal	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licen	maw	P	.O. Bo	Address of Facility New X 275, Gran	ntsville	MD :		P.A.	
	Physician		23a. Part1. En er the disease, or com shock, or hart failure. List only Immediate Carse (Final disease or condition	plications that caused the dea		de me	1.0	ac or respiratory ar	rest.		Approximate Interval Bette Onset and (ween
0,	Medical Examiner sicien and parial-transit	Examiner	resulting in death) Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last	Due to (or as a consect Due to (or as a consect Due to (or as a consect	quence of):	actua	a the	WALL THE BY MEDICALE	XAMME		day	5
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Q	sign d be	ρ	Part II. Other significant conditions of	ontributing to death but not re	sulting in the u	inderlying cau	se given in Part I.		obacco use		o the cause of d	
Vital Records,	e - e	Completed						24a. Was autop perfo		24b. Were a phor to death?	utopsy findings completion of c	available ause of
a	ilcian: Th certificete rector, pag		05 194		_			1 Yes	2 No	1 🗆 Yes	2 No	
₹	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:	1		Other	ath (Check only o				
	Phys raldi	٦.	N Yes 2 No 27. Manner of Death	19⊈Inpatient 2 ☐ 28a. Date of Injury	28b. Time a		4 ☐ Nursing Injury at	Home 5 ☐ Resid			icify)	
C	ding h. After fune	둳	1 □Natural 5 □ Pending	Of Month, Day Year)	Unknow	- 1	Work? 1 ☐ Yes 2 🛣 No	Subjec				
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Ω	pitat c		20a Cartifica 1 Cartifying Dh	Home				Apt. 2	Swant	on, ML		
	Hospitat 24 hours a Funerai C etely filled i	edicai	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the best of my kn niner: On the basis of examin pand manner stated.	owledge, deat ation and/or in	n occurred at ivestigation, in	the time, date and place my opinion, death occ	e, and due to the curred at the time.	cause(s) a date and p	nd manner a lace, and du	s stated. a to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	W.C.	/	29c. l	icense number		29d. Date	signed (Mon	th. Day, Year)	
)	- S → G	ار	Duriela	B D		1 M	64302		110	1109		
		8	30. Name and address of person who	completed cause of deal (Ita	m 23a) (Tyne	Print)	0 . 0 - 0		1/2	1101		
		VA	Daniel A. Buckir				., Oakland,	MD 215	50			
	Sta Registi		31. Date filed (Month, Day, Year) JAN 2 6 20	32. Registrar's Sign								

Amend #5, per Inf G888 2/18/09 TT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Day Year av 101 01 2009 lemphis 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death . 4100 M100 REGIONAL Peninsuch MedICAL Centu 50/156414 If Under 1 Year 8. Date of Birth (Month) Day, 9. Birthplace (State or Foreign Country) . Age (In yrs. last birthday) 1 X M 2□F Months Days Min 80 0 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 □ No Yriness Domers 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 11956 21853 ane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2XNo If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life_DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) employed odfer 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 9a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lane PRINESS Anne MelissA aylor granddaughter MO 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12009 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 917 W. Farbella Street Bennie Smith Huneral MD 21801 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Undering Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 dinknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 22 No 1 ☐ Yes_ 2 GNo 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 □No 1 ☐ Yes 1 Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? 1 Watural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only

Physician /Medical Examiner The law requires that the death certificate be executed Box 68760, P.O. Division of Vital Records, I or Attending Patter death.
Director: After i To the Hospital or within 24 hours are To the Funeral D

Physician

/Medical

Examiner

Funeral

Director

show

Director

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Completed

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Physician/Medical

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Completed

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Certification: To

Medical

29b. Signature and title of certifier

burial-transi and

attending physician for use as the burial

been signed by the a should be detached f

page 2 s has

the funeral director,

filled in by

certificate

this

After

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exactions must be notified at

Baltimore, Maryland 21215-0036

State Registrar

1)

100E

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HEIMAN

29c. License number

29d. Date signed (Month, Day, Year)

			i icasc i	State of Maryland			nd Mental Hva	iene	00016
			For State Registrar	otato or marytana		ate of Death		iene 2009	03346
		4	Decedent's Name (First, Middle, Last)				2. Date of Deat Month	h Day Year	3. Time of Death
	Physicia /Medic			land Teagar			Januar		
	Examin	er	4a. Fecility Name (If not institution, give si			ty, Town, or Location of	f Death	4c. County of Death	_
is.	Funeral		147 Hill Side D 5. Social Security Number 6. Sex	7. Age (In yrs. las	t birthday) If Un-	akland der 1 Year If Under 2		Garret 9. Birth	pplace (State or Foreign untry)
	Director		212-24-0532	M 2□F 80	Yrs. Month	s Days Hours	Min. (Month, Day,		
	and W		Usuel Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location		· · · · · · · · · · · · · · · · · · ·		10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show crinist be notified at	tor	MD Garrett	. Oa	kland				1 ☐ Yes 2 🙀 No
	or 28a	Director	10e. Street and Number		10f.	Zip Code	1	0g. Citizen of What Co	untry?
	ath wi		147 Hill Side D			1550	. 0./0	USA 14. Race - Ame	rican Indian
	lteme	Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married	2. Was Decedent Ever in U.S. Armed Forces? 1 □ Ves 2 □ No	13. Was De If Yes, s	pecify Cuban, Mexican,	in? (Specify Yes or No- , Puerto Rican, etc.)	Black, White	
920	172 hours after death with the Marylan "natural", or Items 23a or 28a-1 show cites! Examiner must be notified at	þ	3 Widowed 4 Divorced	1 Hyes 2 □ No If Yes, Give Year or Dates: 1946 -	-47 1□ Yes	2 № No Specify:		Specify: Wh	ite
Maryland 21215-0036	72 ho	Completed	15. Decedent's Educ (Specify only highest grade	ation	16a. Decedent's U	work done during most		16b. Kind of Business/	ndustry
121	within 72 ene. than "nat	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)	ife. DO NO			Trucking	~
d 2	Hygi Hygi other	e Co	12. Father's Name (First, Middle, Last)		Truck D		r's Name (First, Middle, I		<u> </u>
<u>lan</u>		To Be	Rev. Harold O.	Teagarden		Mabe	el Morgan		
ary	d 2 should th and Men 7 is marke traumatic	'n.	19a. Informant's Name/Relationship (Type	1			r or Rural Route Number		
	of Health item 27 other tr		Hazel M. Teagar	20b. Plac	ce of Disposition (Name of	o., Oaklan	ad, MD 21. 20c. Location - City or	
altimore,	0 0		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	netery, crematory	or other place)	Jan 23, 09		
Ħ.	# 문원를 .		21. Signature of Funeral Service Lidense				Newman Fu		
ä	Depa Impo any i		1 Lunge	uncle	203	S. Second	St., Oak	land, MD	21550
Ε			23a. Part1. Enter the disease, or complice shock, or heart adure. List only on	ations that caused the death.	Do not enter the r	node of dying, such as	cardiac or respiratory arr	est,	Approximate Interval Between Doset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	COPD					year
	Examiner			Due to (or as a conseque					Vean
	Vert the	ner	Sequentially list conditions, if any, leading to immediate cause. Enter linderlying	Due to (or as a conseque					7-0
	ecuted and transi	Examiner	rany, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	inga of):				
760,	le be executed ysician and e burial-transit	cal E	Todaking in county and	Due to (or as a conseque	ince or,				
687	2 0		0						
Вох	Jeath certificate attending phy of for use as the	M/UE	23b. was decedent pregnant	3c. If yes, outcome of pregnand		c pregnancy		23d. Date of del Month	ivery Day Year
0	e deal the att	Physiclan/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time of dea 9☐ Unknown	ith 5 ☐ Dther	(specify)		WOTOT	Day Toal
۹.	that the de ed by the detached	/ Ph	Part II. Other significant conditions cor	tributing to death but not result	ing in the underlying	ng cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
rds	quires n sign ald be	d b	CAD pulm	HTN, HT	w, dy	rashlye HA	1 pt/Y	es 2□No 3□Pr	obably 4 Unknown
Vital Records,	Attending Physician: The law requires that the death certifical rideath. ector: Mer this certificate has been signed by the attending phy the "uneral director, page 2 should be detached for use as the page."	Completed by	Kight side HF	Demanto,	Marrel	45 csoph	24a. Was a autops		itopsy findings available completion of cause of
ž	The Tate has page	Com	bashins sa	cool de cubifus	ulcers	BPH mon	perfor	m ? death? 2 No 1 ☐ Yes	2□ No
Vita	ician: certific	Be	25. Was case referred to medical examiner?	ospital:	D	Other	of Death (Check only or		
ō	Phys ar this eral dir	n: To	1 ☐ Yes 2 2 No 27. Manner of Death		28b. Time of	DDA 4 Nu 28c. Injury at Work?	rsing Home 5 Resid 28d. Describe h	ow injury occurred	ciry)
<u>S</u>	ttending fideath.	atto	1 Natural 5 Pending investigation	(Mornin, Day 1 dai)	Injury M	1 Yes 2	No		
Division of	for Attendate after death Director:	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, street, fac	ctory, office	28f. Location (S City or Tow	itreet and Number or Ri n, State)	ural Route Number,
	Hospital or 24 hours afte Funeral Dir tety filled in		29a. Certifier Certifying Phys	sician: To the best of my know	ledge, death occur	red at the time, date an	d place, and due to the c	ause(s) and manner as	s stated.
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical Examination)	ner: Dn the basis of examination and manner stated.	on and/or investiga	tion, in my opinion, dea	th occurred at the time, o	date and place, and due	to the cause(s)
	within To th	Σ	29b. Signature and title of certifier	7 2		29c. License number H-0064705		29d. Date signed (Mont	h, Day, Year)
,		in	Mary	N		000 1700		1/20/0/	,
		MA	30. Name and address of person who co	311	N 4th	St Oaki	and, MD 2	1550	
	St	ate	Richard A. Port	er 32. Registrar's Signatu	ite	ver vak L	and, MD 2.	1350	
	Regist	rar	JAN 2 6 201	M M	A BOMAKO	200			

DHMH 17 Rev 1/2001

ORIGINAL

09-00660	
Jayden Woods	

ayden Woods		State of Maryla I-For State Registrar	ind / Departmen <i>Certificate</i>	it of Health and e <i>of Death</i>	d Mental Hy	-	200	9 0334
Physiciar ledical Examin	1/	1. Decedent's Name (First, Middle,Last) Jayden Woods			7	2. Date of Death Month	Day Year	3. Time of Death 1020 hrs
Culcal Examini		4a. Facility Name (if not institution, give street and nur	mber)	4b. City, Town, or I	Location of Death	January 22	, 2009 4c. County of Death	
	Н	6309 Powhatan Street		Riverdale			Prince George	e's
Funeral Director		216-83-6401 1XM 2 F	7. Age (In yrs. last birthda	yrs. If Under 1 Year Months Days		8. Date of Birth Nov 19	(MM/DD/YYYY) 9. Bir Foreig Co	
any	H	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or I	Location				10d. Inside City Limits
* .	۱ځ	Maryland Prince George'	s Riverda	ale				1 X Yes 2 No
th the Maryland 23a or 28a-f she notified at once		10e. Street and Number		10f. Zip Code	-		g. Citizen of What Cou	
th the		6309 Powhatan Street	The state of the s	20737			United Sta	
er death w	Fune	11. Mantal Status 1 X Never Married 2 Married Armed For I Yes 3 Widowed 4 Divorced If Yes, Give Year	orces?	3. Was Decedent of His If Yes, specify Cuban 1 Yes 2 V No	, Mexican, Puerto I		White, etc.	ican Indian, Black, African erican
natura xamir	핡	15. Decedent's Education (Specify only highest grad	duri	cedent's Usual Occupati			16b. Kind of Business/	Industry
215-0036 be filed within 72 h that Hygiene. ked other than "r ent, the Medical E	Completed	College (1 0 years 17. Father's Name (First, Middle, Last)	-4 or 5+)	None			None	•
215- oe filed ntal Hyg ked otl	Be C	Robert Thomas Woods,	II		18.Mother's Name Tiara	C.M. Ja	,	
MD 21.	2	19a. Informant's Name/Relationship (Type, Print) Robert T. Woods, II - Fa		Mailing Address (Stree 09 Powhatan				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If iteu 27 is marked other than 'injury or other tranmatic event, the Medical		20a. Method of Disposition Burial 2 X Cremation 3 Removal fro Donation 5 Other Specify:	om State crematory	Disposition (Name of centrol or other place) Crematory	·	Date 2, 2009	20c. Location - City or Cli	Town, State
Baltin permit. Departm Importa	1	2 Sinature of Funeral Service Licensee	m An	22. Name and Address	St		uneral Homo	
Physician		23a. Part 1. Enter the disease, or complications that ca failure. List only one cause on each line.	aused the death. Do not e	nter the mode of dying,	such as cardiac or	respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
/Medical xaminer			unexplained consequence of):	d death in	infancy	(SUDI)		Death
	<u>ا</u> ه	Sequentially list conditions, if any, leading to immediate b. Due to (or as a	consequence of):		-			
	amine	cause. Enter Underlying Cause (Disease or injury that initiated	consequence of):					
+	ŭ	d.						
50, tte be exec 1ysician a	dica	X UNPENDED AMENDED	23a,27,28a-f	, perME, g	889 3/30	/09 TT		
Box 68760, re death certificate be the attending physic red for use as the burned for us		23b. Was decedent pregnant in the past 12 months?	outcome of pregnancy irth 2 ant at time of death 5	Fetal death 3	Ectopic pregnal	ncy	23d. Date of deliver Month	y Day Year
Box (e death co	Physi	1 Yes 2 No 9 Unknown g Unknown	- L	Other (Specify)				
ires that the signed by I be detach	출	Part II. Other significant conditions contributing to	death but not resulting in	the underlying cause g	given in Part I.		pacco use contribute to	_
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transition of the funeral director, page 2 should be detached for use as the burial - transition of the funeral director, page 2 should be detached for use as the burial - transition of the funeral director, page 2 should be detached for use as the burial - transition of the funeral director o	ompleted					24a. Was a autops perform	by prior to med? death?	utopsy findings available completion of cause of es 2 No
tal Rection: The certificate ector, page	Be C	25. Was case referred to medical examiner?			of Death (Check of	nly one)		
of Vi	٥,	examiner? 1 ✓ Yes 2 No Hospital: 1 1 27. Manner of Death 28a. Date					Residence 6 Othe	r: Scene
nding rth.	<u>:</u>	1 Natural 6 (Month	, Day, Year)		res 2X No	unk	ow injury occurred	
Division pital or Attendiours after death. leral Director: /	ertification:	2 Accident investigation	e of Injury - At home, farm	, street, factory, office b	puilding, etc.	28f. Location (S or Town, St Riverda	treet and Number or Ruate) 6309 Pow	ural Route Number, City hatan St
Division To the Hospital or Attent Within 24 hours after death To the Funeral Director: Completely filled in by the	edical C	29a. Certifier 1 Certifying Physician: To the bes one) 2 Medical Examiner: On the basis of and manner significant Certifier Certifier Physician: To the basis of and manner significant Certifier Physician: To the basis of an annex of the certifier Physician: To the basis of the certifier Physician: To the certifier Physicia	at of my knowledge, death	occurred at the time, da		due to the cause	e(s) and manner as stat	
E S E S	<u>₽</u>	29b. Signature and title of certifier		29c. License	e number		29d. Date signed (Mo	nth, Day, Year)
		Calif		O.C.1	M.E.		January 23, 200	9
CR !	1	30. Name and address of person who completed cause Zabiullah Ali, M.D. Assistant Medic		Penn Street Ralti	imore MD 211	201		
Sta	te				THOIG, WID 212			
Registr	ar	31. Date filed (Month, Day-Year) JAN 3 0 2009	egistrar's Rignature					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 17, Month **Physician** 2009 3:49 a M January John Henry Watkins, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince Georges Cheverly Prince George's Hospital Center 8. Date of Birth (Month, Day, You 25, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number **Funeral** Hours Year Days 1**√**□ M 2□ F Months 220-30-3193 1931 Harwood, Md. **Director** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10h County show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the "Modeal Evancina" will be notified at 1 Yes 2 No Capitol Heights Director Prince Georges 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 20743 620 Hedgeleaf Ave. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 € No Specify: Black 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education 72 (Specify only highest grade completed) d 2 should be filed within thand Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Private Warehouseman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rena Johnson John Henry Watkins, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 620 Hedgeleaf Ave. Capitol Heights, Md. 20743 Department of Health a Important: If Item 27 is any injury or other trangonce. Wife Vanessa Elaine Watkins / 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition Pages 1 1 Burial 2 □ Cremation 3 □ Removal from State 1/24/2009 Landover, Md. Harmony Memorial 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Alexander S. Pope / P.A.
5538 Mariboro Pike/Forestville, Md. 21. Signature of Funeral Service License 20747 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hypertensive Cardiovasculiar Disease **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions Due to (or as a sunsequence of). Examiner in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed ending physician and use as the burial-transi Congestive Heart Failure resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Physician/Medical Status Past Defribillater has been signed by the attending I e 2 should be detached for use as IF FEMALE. 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy certificate ha rector, page 2 1 ☐Yes 2½ No or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending e Funeral Director; Affoletely filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide Hospital 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier January 21, 2009 D31528 30. Name and address of person who completed cause of death (Item 232) (Type, Print)
Margaret Akpan, M.D. 3001 Hospital Dr. Cheverly, Md. Margaret Akpan, M.D. U 20785 31. Date filed (Month, Day JAN 2 3 2009

DHMH 17 Rev 1/2001

State Registrar

			Please	e Type or Pri							•	
		For State Registrar		State of M	aryian		partment of l Certificate of		nental H	ygiene Reg. No	0000	0331.0
		Decedent's Nam	e (First, Middle, L	Last)					2. Date of D	eath	2000	3. Time of Death
Physici /Medi		Constar	ce Bern	ice William	ns				Januar	y 14	2009 Year	16:00 M
Examir		4a. Facility Name (If not institution, g	give street and number)		4b. City, Town, o	r Location of Death		40	. County of Deat	h
<u> </u>		Souther 5. Social Security N		and Hospita	al ge <i>(In yrs. I</i>	ast hirthd	Clinton	If Under 24 Hrs.	8. Date of B		Prince Ge	eorge's
Funeral Director		579-20-0		1 □ M 2 🖾 F	88 88	Yrs	Months Days	Hours Min.	(Month, L	Day, Year)	Co	untry) DC
ם		Usual Residence o							INOV.I.), 13	720	
anylar show	ō	10a. State	10b. County	George's		, lown oi ⊇s tv j	Location					10d. Inside City Limits 1 Yes 2 No
the M	Director	10e. Street and Nu		George S	FOL	ESLVI	10f. Zip Code			10a. Ci	itizen of What Co	
with		2605 Rv	der Ave.				20747				USA	,
deatl	Funeral	11. Marital Status		12. Was Decedent Armed Forces	Ever in U.S	3.	3. Was Decedent of H	lispanic Origin? (Sp	ecify Yes or N	io-	14. Race - Ame Black, White	
or it	by Fu	1 Never Marr	ied 2 Married	1 ☐ Yes 2 📆			1 □Yes 2 No	Specify:	riioan, oto.,		Specific	
tural'		3 LA vvidowed	15. Decedent's	Year or Dates:		16a. De	ecedent's Usual Occur	pation		16b. K	(ind of Business/l	ack
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ad with ygien ygien t, the	Completed	12			.,	C1e	rical				Governme	ent
be file	Be	17. Father's Name Irving		ist)				18. Mother's Nam			,	
I all yian to Z IZ IS-COOOO 2 should be filed within 72 hours after death with the Maryland 1 and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Experimer must be notified at	မ	19a. Informant's N		(Type Print)		10h M	ailing Address (Street	Catheri				Tin Code)
and 2 s ealth ar ealth ar n 27 is				Daughter			7 Parkland			-		
ore, Intally jailed within 72 hours after death with the Marylan jes 1 and 2 should be filed within 72 hours after death with the Marylan tof Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Example must be rediffied at		20a. Method of Dis	position		20b. P		sposition (Name of crematory or other place		Date		ocation - City or	
Pages ment of ant: If ite			☐ Cremation 3 5 ☐ Other (Special)	☐ Removal from State cify)			Memorial	Jan.	21,2009	Su	itland,	MD
permit. Pages 1 and 2 Department of Health Important: If item 27 i any Injury or other tra		21. Signature of Fu	uneral Service Lic	tensee /	1	1	22. Name and Addre	ess of Facility St	ricklan	id Fu	neral Se	ervices
20260	_	230 Part Fator	the discourse or so	omplications that cause	الموماد المام	Do not	6500 Aller	town Rd.	Camp	Spri	ngs, MD	20748 Approximate
Dharida		shock, or hea	art failure. List on	nly one cause on each I	ine.			_			> 1 A	Interval Between
Physician /Medical		disease or condition resulting in death)	on	a. Due to (or as	Cyt s a consequ		(EYEBY	ovancu	0~	TCC	1 den 1	
Examiner		Sequentially list co	nditions	b	A+	n'a	(eyeby	671190	on			
ed	iner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or	nmediate erlying	Due to (or as			^	tic s	11	C. 1.		
execut and	Examiner	that initiated events resulting in death)	5	c Due to (or as	a consequ		ITOY	to c >	TON	20 2		
te be ex ysician a e burial-				d.								
ntifical ng phy as th	Physician/Medical	IE EENAN E										
ath ce ttendii	an/N	IF FEMALE: 23b. Was deceden in the past 12		23c. If yes, outcome 1 ☐ Live birth			3 ☐ Ectopic pregnance	су			23d. Date of deli	
the a	ysic	1 ☐ Yes 2	No	4 ☐ Pregnant 9 ☐ Unknown	at time of d	eath	5 ☐ Other (specify) _				Month	Day Year
that the the by detac		Part il. Other signi	ficent conditions	s contributing to death	but not resu	Ilting in th	e underlying cause giv	en in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
een sign	ed by	1	toate	Jan 8,00					1 🗆	Yes 2	No 3□ Pr	obably 4 🗆 Unknown
aw re as bee 2 sho	Completed		/ 4						24a. Wa		24b. Were au	topsy findings available
The The page	Com									opsy formed? 2 X No	death?	completion of cause of
vician: certific ector,	Be (25. Was case referexaminer?		Haspital			104	26. Place of Deat				
ding Physician: The law h. After this certificate has funeral director, page 2.4	5. To	1 ☐ Yes 2 🔀 27. Manner of Deat	•	Hospital: 1 inpat	1	ER/Outpa 28b. Tim	e of 28c Inju	4 LI Nursing Ho	ome 5 Res		6 Other (Spec	cify)
nding ath.	ation	1 X Natural 2 ☐ Accident	5 ☐ Pending investigat	(Month, D	ay, Year)	inju	ry Wor	k? Yes 2 □ No	Log. Describe	7 110 W 111 ju	ny occurred	
r Afte er deg recto	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	28e. Place of Ir	jury - At ho	me, farm,	street, factory, office		28f. Location City or To			ral Route Number,
urs aft			V								,	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one)	1 Certifying 2 Medicei Ex	Physician: To the bes caminer: On the basis and manners	of examina	wledge, d tion and/o	eath occurred at the to or investigation, in my	me, date and place opinion, death occur	, and due to the red at the time	e cause(s e, date an	s) and manner as id place, and due	s stated. to the cause(s)
To the within To the complex	Me	29b. Signature and		m'			29c. Licens				ate signed (Month	
^ 1			(2/11	reg	MD		D00	28033		Ja	nury	15,2009
WA		30. Name and add	ress of person wh	no completed cause of	death (Item	23a) (Ty	pe, Print) A. Mi)_ 9135	Pr	sca	taway	15, 2009 Rd- #310
Sta		31. Date filed (Mor	ith, Qay, Year) 🛮	32. Regist	rars Signa	ture		C611	V 1 0 1	, .	nn ac	7/73
Regist	ar	JAM # J	-000	many p.	Man							

			1- For AMEND#29aperCRNP, 1-29-09, BW, MCCO Certificate of Death Reg. No. 0 9 03350
4	Physici /Medic		1. Decedent's Name (First, Middle, Last) 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month, Day 9, 2009 2. Date of Death Day 9, 2009 2. Date of Death Day 9, 2009 2. Date of Death Day 9, 2009 2. Date of Death Day 9, 2009 2. Date of Death Day 9, 2009 Day 1009
*	Examin		4a. Facility Name (If not institution) give street and number) 4b. Cipy Town, or Location of Death 4c. County of Death 4c. County of Death 4c. County of Death 4c. County of Death 4c. County of Death 4c. County of Death
	Funeral Director		5. Social Security Number 054-20-4337A 6. Sex 7. Age (In yrs. last birthday) 1 Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Year) 9. Birthplace (State or Foreign Months Days Hours Min. Months D
	Maryland f ehow	or	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	with the Page or 28a-	i Direct	10e. Street and Number 1235 Potomac Valley Road 10f. Zip Code 20850 10g. Citizen of What Country? United States
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If them 27 is marked other then "natural", or items 23a or 28a-f ehow appring injury or other traumatic event, The Medical Examinar must be notified at another.	by Funeral Directo	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Marned 1 Never Married 2 Marned 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Secretive Specify Yes or No-Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Black, White, etc.) 14. Race - American Indian, Black, White, etc. 15. Was Decedent Ever in U.S. Armed Forces? 1 Secretive Specify: White
21215-0036	within 72 ho jiene. r then "naturi I're Medicel I	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0.12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Home Parent 16b. Kind of Business/Industry Social Services Agency
Maryland 2	uld be filed fental Hygir rked other tic event,	To Be C	17. Father's Name (First, Middle, Last) Philip Portnow 18. Mother's Name (First, Middle, Maiden Surmame) Jennie Terr
	and 2 should salth and Men n 27 Is marke ler traumatic		19a. Informant's Name/Relationship (Type, Print) Philip Reed West -son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3409 Woodley Road, N.W. Washington, D.C. 20016
Baltimore,	Pages 1 a nent of He int: If Item iry or othe		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) New Montefiore Cemetery 1/21/2009 West Babylon, NY
Balti	permit. Departn Importe any injt		21. Signature of Funeral Service Licensee Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland20705
T.	Physician		23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Dichete & Mellitus) The condition of the cause of the
. 0	/Medical Examiner		Due to (or as a consequence of): Covenary Attery Discase b. Covenary
B	ecuted and -transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):
8760,	certificate be executed uding physician and use as the burial-transit		d.
O. Box 6	death e atter	Physiclan/Medical	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery Month Day Year 23d. Date of delivery Year
ds, P.	20.00	by	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 70 3 Probably 4 Unknown
of Vital Records,	× 20 0	Completed	delusions 24a. Was an autopsy findings available prior to completion of cause of death? 24b. Were autopsy findings available prior to completion of cause of death?
Vital	Physician: The la r this certificate ha ral director, page 2	Be	25. Was case referred to medical examiner? Hospital: Hospital: Description of Death (Check only one)
ion of	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.	ation: To	27. Manner of Death Natural 5 Pending 2 Accident Investigation Pending 2 Accident Pending 2 Accident Pending 2 Accident Pending 2 Accident Pending 2 Accident Pending 2 Accident Pending 2 Accident Pending Pendi
Division	ital or Att irs after de ral Directi led in by t	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	the Hosp in 24 hou the Funal iplately fil	edical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) Nurse Practitioner and manner stated.
) _	2 2	Σ	29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) TAN/19/09
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1010 Molecular DR # Je 6 NAM HAJNOT CROP Recluim Mel 20850
1	Sta Regist		31. Date filed (Month, Day, Year) 33. Registrar's Signature 34. Aparell 35. Aparell

Physician /Medical Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

	1 - State Registrar	Certificate	of Death	Reg	1. No.2 0 0 9	03351
an	Decedent's Name (First, Middle, Last)			2. Date of Death Month	Pay o Xearo	3. Time of Death
al	Jane Pratt Wood			January	fg, 2009	10:23 PM
er	4a. Facility Name (If not institution, give street and number) Calvert Manor Healthcare Center		own, or Location of Death ng Sun	1	4c. County of Death	1
	5. Social Security Number 6. Sex 7. Age (In yrs. las 1 M 2 7 F 104	t birthday) If Under 1 Yrs. Months		8. Date of Birth (Month, Day,) July 9. 1	rear) Cou	nplace (State or Foreign intry) yland
	Usual Residence of Decedent	Town or Location				10d. Inside City Limits
'n	, , , , , , , , , , , , , , , , , , , ,	North East				1 □XYes 2 □ No
ectc	10e. Street and Number	10f. Zip C	odo	100	g. Citizen of What Cou	
ğ		101. Zip 0	21901	100	United St	•
era	101 George Street 11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decede	nt of Hispanic Origin? (Spy Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Amer	
Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give			o Rican, etc.)	Black, White	
by	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 □ Yes 21	No Specify:		Specify: Wh	ite
etec	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual (Give kind of work	Occupation done during most of work retired)	king I	6b. Kind of Business/I	ndustry
m m	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use Homemake			Own Home	
Be Completed by Funeral Director	17. Father's Name (First, Middle, Last)		18. Mother's Nam	ne (First, Middle, Ma	aiden Surname)	
) Be	John Futty			e Pratt	,	
ျှ	19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Address (3	L Street and Number or Ru	ıral Route Number, (City or Town, State, Z	ip Code)
	Nancy Ball / Daughter	404 Carolyn	Avenue, No	rth East,	Maryland	21901
	Cen	e of Disposition (Name netery, crematory or oth	of er place) Janu	Date 23,	Oc. Location - City or 1	Town, State
	1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Har	t's Cemeter			k Neck, Ma	aryland
	21. Signatur Furral Prince Cen	22. Name and	Address of FacilityCro	uch Funer	al Home	
	Vall- Car					ryland 21901
, ,	23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.				it,	Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) Fault	ure to ti	nrive			
	Due to (or as a consequer	nce of):	rvive Dementia			
ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	STAGE I	remention			
ä	Cause (Disease or injury	TN				
Exa	that initiated events c. Due to (or as a consequer	nce of):				
Medical Examine	d C	AD				
	IF FEMALE:					
ian/	23b. Was decedent pregnant In the past 12 months?	eath 3 □Ectopic pre			23d. Date of deliment	very Day Year
ysic	1 □ Yes 2 No 9 □ Unknown	th 5 ☐ Other (spec	<i>my)</i>			
Completed by Physician/	Part II. Other significant conditions contributing to death but not resulting	ng in the underlying cau	se given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
q p	PVD			1 ☐ Yes	2 X No 3 □ Pro	obably 4 □Unknown
olete	OA			24a. Was an	24b. Were au	topsy findings available
mo				autopsy performe 1 Yes 2		ompletion of cause of 2 ☐ No
Be C	25. Was case referred to medical examiner?		26. Place of Dea	th (Check only one)		2 140
To	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ EF	N/Outpatient 3 DOA		ome 5□Residen	ce 6 □Other (Spec	eify)
on:	1 Natural 5 Pending (Month, Day Year)		c. Injury at Work?	28d. Describe how	injury occurred	
cati	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of injury - At home	M	1 ☐ Yes 2 ☐ No	006 1 10 /01		
ertif	4 Homicide determined building, etc. (Specify)	e, fami, street, factory,	Since	City or Town,	et and Number or Ru State)	rai noute Number,
Medical Certification:	29a. Certifier 15 CertifyIng Physician: To the best of my knowle	edge, death occurred at	the time, date and place	e, and due to the cau	use(s) and manner as	stated.
edic	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	n and/or investigation, i	n my opinion, death occu	urred at the time, dat	te and place, and due	to the cause(s)
ž	29b. Signature and title of certifier	29c. 1	icense number	290	d. Date signed (Month	i, Day, Year)
	SHAHNAWAZ KHAN MD	My A	D62190		1-20-6	09
	30. Name and address of person who completed cause of death (Item 20	Sa) (Type, Print)	INE FIX	TON . A	MD 2192	i .

State

Registrar

31. Date filed (Month, Day, Year)

JAN 22 2009

5

parked.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2009 03352 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 22 Month 01 09 Cinderella Mae Wilburn 0933 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death ALLEGANY WMHS-BRADDOCK CAMPUS CHMBERLAND If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. | May 1, 1959 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 1 □ M 2√2√F Mary land 49 215-74-8280 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1X Yes 2 □ No Grantsville MD Garrett 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21536 USA 500 Casselridge Drive, Apt 32 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Specify: white 1 □Yes 2 No Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cook Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rachel Gregory Delbert T. Roy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 500 Casselridge Dr., Apt 32, Grantsville, MD 21536 Ricky D. Wilburn, husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Jan. 26, 2009 Grantsville Cem. Grantsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Newman Funeral Homes, P.A., P.O. Box 275 179 Miller St., Grantsville, MD 21536 23a. Part1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Dua to (or as a consequence of): neumothoras cell with neuroendarine nonsmul naconcer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last obst hronic Due to (or as a consequence of): IF FEMALE 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No 24a. Was an nut autopsy performe 1 ☐Yes 2 26. Place of Death (Check only one) 1 Yes ♠No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 10 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Box 68760, P.O. Records, Division of Vital

Physician/Medical

Completed

Be

Certification: To

Medical

Physician

/Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

permit, Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventine must be netified at once.

Baltimore, Maryland 21215-0036

cate has been signed by the attending physician page 2 should be detached for use as the buria certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I

25. Was case referred to medical examiner?

3 ☐ Suicide 4 Homicide

(Check only one)

29a, Certifier

6 ☐ Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
Collapsed in its ly at home

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

D0066439

29c. License number

29d. Date signed (Month, Day, Year) January 22, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mauromatis Drive, Cumberland, MD 21502 904 Seton

and manner stated.

State Registrar

			For State Registrar	State of Mai	ryland / I	-	artment of H rtificate of L		i Mental Hy	gien Reg. N	ie ie 2009	3 0	3353
	Dhualais		1. Decedent's Name (First, Middle, Last)		_				2. Date of De Month	ath	ay Year	3. T	ime of Death
,	Physicia /Medic			avendish	Weston				Januar	y 19	2009	10	0:50A M
	Examin	er	4a. Facility Name (If not institution, give st	_			4b. City, Town, or		ath		c. County of Dea		
É	Funeral		Anne Arundel Medica 5. Social Security Number 6. Sex		(In yrs. last bi	rthday)	Annapoli If Under 1 Year	If Under 24 H			Anne Aru	rthplace (State or Foreign
ı	Director			M 2□F 68		Yrs.	Months Days	Hours Mi	6/11/1	940 940	Noi	th C	arolina
	p ≥		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Lo	cation					10d. ln	side City Limits
	laryla shov	ō					odtion						∐Yes 2√∏No
	the N	Director	Virginia Prince Wil	liam	Dumfri	.es_	10f. Zip Code			10g. (Citizen of What C	ountry?	
	h with	al Di	17060 Capri Lane Ca	203			22026	ó		U	SA		
	ems ?	Funeral	11. Marital Status	2. Was Decedent Ev Armed Forces?		13.	Was Decedent of H	ispanic Origin? ın, Mexican, Pu	(Specify Yes or No erto Rican, etc.))-	14. Race - Am Black, Wh		dian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Modical Examination and be notified at once.	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ∐Yes 2∭ No If Yes, Give Year or Dates:)		1 □Yes 2 📆 No	Specify:			Specify: W	hite	
21215-0036	hour	edk	15. Decedent's Educa	ation	16a	. Dece	dent's Usual Occup	ation		16b.	Kind of Busines		
215	hin 72 e. an "na Madii	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	`life.	kind of work done on NOT use retired	during most of w l)	vorking				
2	ed wit ygien ner th:	Con			В	rick	Mason	40.14.4.4.4.	1 (Pinak 6.8)		nstruct	ion	
and	be fill ntal H ed oth	Be	17. Father's Name (First, Middle, Last) Everette Len Weston	n				_	_{lame (First, Middle} ane Caver				
Ž	thould nd Me mark matic	욘	19a. Informant's Name/Relationship (Type		191	o. Mailir	ng Address (Street			-		Zip Code	······································
ĕ ≥	nd 2 salth ar		Gina L. Goncz/Daug		50	00 (Giddings	Ave. An	napolis.N	1D.	21401		
J.e.	es 1 a of He fitem		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	mount from Ptoto	20b. Place o	of Dispo	sition (Name of natory or other plac	e)	Date	20c.	Location - City of	r Town, S	tate
Ĕ	Pag ment ant: I		4 □ Donation 5 □ Other (Specify))	Kala		rematory				ewater,		
Baltimore, Maryland	permit Depari Import any In		21. Signature Funeral Service License-	Á			2. Name and Addre		-				
	HD = 60		23a Part 1 Enter the disease or complice	ations that caused t	he death Do		973 Solomo				water, Ma	Appr	oximate
E	Dharisina		23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final	cause on each line	3		1	·g/	,	,		Onse	val Between et and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a	neun		114			-			minth.
	Examiner		h	`		,							
	₽ ≒	iner	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence	of):							
	xecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence	of):							
68760,	ficate be executed physician and s the burial-transit	al E		240 10 (07 40 4		,-							
687	tificate g phyas as the	edical	a.			725							
Box	eath certific attending p for use as t	Physician/M	23b. was decedent pregnant	c. If yes, outcome o		h 3[☐ Ectopic pregnanc	у			23d. Date of d	elivery Day	Year
о Ш	ie dea the at hed fo	sici	in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of death	5 [Other (specify)				WIGHT	Day	1641
P.0.	w requires that the despension of the should be detached	Phy	Part II. Other significant conditions cont	ributing to death but	t not resulting	in the u	nderlying cause giv	en in Part I.	23e. Did	tobacc	o use contribute	to the cau	use of death?
ds,	ulres i signi Id be	d by	ALS						_ 1 🗆	Yes	2 □ No 3 💢	Probably	4 🗌 Unknown
S	w req	Completed	COPD						24a. Was				ndings available
Re	The la	ome	palmonay -	e na belier					— auto perf 1 □ Yes	ormed?	death:		ion of cause of
/ital	clan: ertifica ctor, p	Be C	25. Was case referred to medical examiner?						Death (Check only				
Division of Vital Records,	Physic this o		1 ☐ Yes 2 No	1 Inpatier 28a. Date of Injur	1 2 ER/C	utpatie Time o		4 🖂 Nursin	g Home 5 ☐ Res			necify)	
On O	ding I h. After funer	tion	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day,		Injury	Worl	yai k? Yes 2∐No	280. Describe	HOW III	jury occurred		
/isi	I or Attendi after death. Director: A d in by the fu	ifica	3 Suicide 6 Could not be	28e. Place of Injur	ry - At home, f	arm, st	reet, factory, office		28f. Location	(Street	and Number or	Rural Rou	te Number,
ă	tal or is afte al Dire	Certification; To	4 ☐ Homicide determined	building, etc.	. (Specify)				City or To	iwii, Su			
	To the Hospital or Attending Physician: The law requires that the death certifully a thours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier 1 Sertifying Physical (Check only one) 2 Medical Examin	er: On the basis of	examination a								
	o the	Med	29b. Signature and title of certifier	and manner stat		-	29c. Licens	e number	}	29d. I	Date signed (Mo	nth, Day,	Year)
	->-0		ANTA to		uD		カス	804		1	-19-20	900	
	MIL		30. Name and address of person who cor	npleted cause of de	ath (Item 23a	(Type,	Print)		nopola		110		
0	OF		31. Date filed (Month, Day, Year)	-terson	r's Signature		AAM	CA	unofelia	>	Md 2	140	/
	Sta Registr		JAN 2 1 200	19	r's Signature	1	tike						
	-		#1111 N × CO	A SECONDO	Vis a	100							

DHMH 17 Rev 1/2001

			For State	State of Ma	-			Mental Hy	giene	
			Registrar 1. Decedent's Name (First, Middle, La	st)		ertificate of	Death	2. Date of De	Reg. No. 2	009,0335
	Physici /Medio		ANNA MAE	WILES				JANUARY		Year 2:50A M
1	Examir		4a. Facility Name (If not institution, giv			-	r Location of Dea	th		y of Death
		м	FREDERICK MEMORIA 5. Social Security Number 6. S		(In yrs. last birthday	FREDERI If Under 1 Year	CK	8. Date of Bir		ERICK
	Funeral Director			M 2 X F	77 Yrs.	Months Days	Hours Min		ıy, Year)	9. Birthplace (State or Foreign Country) Maryland
	pu »		Usual Residence of Decedent 10a. State 10b. County		40- Oit- T				, .,,,,	
	faryla shov	ō	10a. State 10b. County Maryland Freder	rick	10c. City, Town or L	ocation	Keymar			10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	the N	irect	10e Street and Number 12526 Woodsboro P			10f. Zip Code	TCynici		10g. Citizen of	What Country?
	th with	al D	12526 Woodsboro P	ike			21757		i	USA
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examprer must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🌠 Widowed 4 ☐ Divorced	12. Was Decedent E- Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates:	ver in U.S. 13	Was Decedent of Hif Yes, specify Cub. 1 ☐ Yes 2 No	dispanic Origin? (an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	14. Ra Bla Speci	ice - American Indian, ack, White, etc. fy: WHTTE
5-0	72 hou	eted	15. Decedent's Ed (Specify only highest gra	lucation	16a. Dec	edent's Usual Occup kind of work done	pation	rkina	16b. Kind of E	Business/Industry
21215-0036	2 should be filed within and Mental Hygiene. is marked other than "aumatic event, Ibe Men	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	life	DO NOT use retired	d) most of wo	irkuig	Rest	taurant
pu	tal Hyg	Be C	17. Father's Name (First, Middle, Last)					me (First, Middle,		me)
Maryland	should be f and Mental s marked of umatic eve	2	William J. Bla					y May Moi		
Ma	d 2 sh tth and 27 is n traun		19a. Informant's Name/Relationship (Michael Wiles, so			ing Address (Street 26 Woodsbo				
	s 1 and 2 of Health item 27 i		20a. Method of Disposition			osition (Name of matory or other place		Date		- City or Town, State
<u>=</u>	Page ment c ant: If ury or		1 N Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify			orings Cen		21/2009	Rocky	Springs, MD
Baltimore,	permit. Pages 1 and 3 Department of Health Important: If Item 27 any injury or other tr once.		21. Signature of Funeral Service Licer	Subor	no 2	2. Name and Addre		Myers-Dur Mitsburg	boraw E , MD 21	Funeral Home 1727
		/	23a. Part 1 Enter the disease, or com shock, or heart failure. List only	plications that caused to one cause on each line	he death. Do not er	ter the mode of dyin	ng, such as cardia	c or respiratory a	rrest,	Approximate Interval Between
and of	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		CANCER					Onset and Death
7	Examiner		1	Due to (or as a	consequence of):					
	it od	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	consequence of):					
	tificate be executed g physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):					
68760,	e be e rsician e buria	cal E		d						
	± 0, 60	ledical		u						
.O. Box	The law requires that the death cert ate has been signed by the attending page 2 should be detached for use a	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at 1 9 ☐ Unknown	Fetal death 3	☐ Ectopic pregnand ☐ Other (specify) _	у		1	ate of delivery onth Day Year
σ.	s that gned b e deta	by Pr	Part II. Other significant conditions of	ontributing to death but	not resulting in the	underlying cause giv	en in Part I.	23e. Did to	obacco use con	tribute to the cause of death?
of Vital Records,	w requires been sign should be					-		1 🗆 ነ	′es 2□No	3 ☐ Probably 4 ☐ Unknown
eco	law r nasbe s 2 sh	Completed						24a. Was	sy	Were autopsy findings available prior to completion of cause of
교	ian: The law rtificate has stor, page 2 s			·					rmed? 2 🕅 No	death? 1 □ Yes 2 □ No
Vit	S S S) Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	t 2 ☐ ER/Outpatie	nt 3 🗆 DOA Oth		ath (Check only o		
	ding Phys h. After this funeral dii	n: To	27. Manner of Death	28a. Date of Injury	28b. Time (of 28c. Injur	y at	dome 5 ☐ Resid		
sior	ent at	atio	1 Matural 5 Pending 2 Accident investigation	1	Year) Injury	M 1 🗆	Yes 2 □ No			
Division	al or Attending s after death. I Director: After d in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injur building, etc.	y - At home, farm, st (Specify)	reet, factory, office		28f. Location (S City or Tow	Street and Numi vn, State)	ber or Rural Route Number,
	To the Hospital or Atta within 24 hours after de To the Funeral Direct completely filled in by th	Medical (29a. Certifier 1	ysician: To the best of niner: On the basis of and manner state	examination and/or i	th occurred at the ti nvestigation, in my c	me, date and place ppinion, death occ	e, and due to the urred at the time,	cause(s) and m date and place,	nanner as stated. and due to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date signe	ed (Month, Day, Year)
	WJL			Usen		MDH64	135		1/19/	2009
	3		30. Name and address of person who safrina Hasan 4	completed cause of dea	ath (Item 23a) (Type treet Fr	Print) ederick,	Md 2170	1		
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar	's Signature	1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 03355Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** January 29, Edward Eugene Watson 2009 0452 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Union Hospital E1kton If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1**X** M 2□ F Director 69 213-36-9293 1939 North Carolina April 18, Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or Items 23a or 28a-f show traumatic event, I'm Madical Examinating rust be notified at 1 ☐ Yes 2 X No Director Maryland Cecil North East 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral 1758 Turkey Point Road United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 M No If Yes, Give Ye ar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: ģ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Automobile and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Parts Man Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles E. Watson Lucy Hamm 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health a:
Important: If item 27 is
any Injury or other trau Clara Esther Watson/Wife 1758 Turkey Point Road, North East, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State January 30, 1 ☐ Burial 2 🗓 Cremation 3 ☐ Removal from State R. A. Ferris & Co., Inc. 4 ☐ Donation 5 ☐ Other (Specify) West Chester, PA 2009 21. Signature of Funeral Service Licensee Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury mon ner Due to (or as a consequence of): The law requires that the death certificate be executed Exami asicinoma physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical signed by the attending I F FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No Ö 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy this certificate 1 ☐ Yes 2 4No 1 ☐ Yes 2 □No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ № 6 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division the Hospital or Attending 5 Pending investigation 1 Matural s after death.

I Director: / death. 1 Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours aff

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State

No.

Dio

Registrar

DHMH 17 Rev 1/2001

and manner stated.

Registrar's Signat

and address of person who completed cause of death (Item 23a) (Type, Print)

		Pleas	e Type or Prir	nt in Bla	ack Ind	lelible Ink	. Ensure A	II Copies	Are Le	egible.	
		For	State of Ma	aryland	•		Health and N	Mental Hyg	giene		
		State Registrar			Cert	tificate of	Death	F	Reg. No. 2	2009	03356
Physici	an	Decedent's Name (First, Middle, I	Last)					2. Date of Dea	ath D <u>ay</u>	Year	3. Time of Death
/Medic			Cecilia Emr	na Wind	sor			Januar		, 200	9 0311 am
Examin	er	4a. Facility Name (If not institution, of Dorchester Ge	neral Hos	spita	(Caml	bridge	1		ounty of Deal	ester
Funeral			. Sex 7. Ag	e (In yrs. lasi	t birthday) _ Yrs.	If Under 1 Year Months Days		8. Date of Birt (Month, Day	v, Year)	9. Birt	hplace (State or Foreign ountry)
Director		214-07-7302 Usual Residence of Decedent		93	110.		<u> </u>	11/12	2/1915		Maryland
/land low at		10a. State 10b. County		10c. City, T	own or Loc	ation					10d. Inside City Limits
Man B-f sh Iffed	io	Maryland Do	orchester				Cambridge				1 X Yes 2 No
th the or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citizer	n of What Co	ountry?
ath wi		40	7 Muir St.				21613		1 44	. Race - Ame	SA
er de items ner m	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑		13. W	Yes, specify Cub	Hispanic Origin? (Sp pan, Mexican, Puerto	pecity Yes of No- o Rican, etc.)	14.	Black, Whit	
irs aft	by F	3 ₩ Widowed 4 Divorced	If Yes, Give Year or Dates:	•0	1	□Yes 2XINo	Specify:		S	pecify:	White
filed within 72 hours after death with the Maryland Hygiene. Hygiene. when than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	ted	15. Decedent's (Specify only highest	Education	Ţ.	16a. Deced	ent's Usual Occu	pation during most of work	king	16b. Kind	of Business	
thin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life. D	O NOT use retire	ed)	Kirig		-	
led wi lygier her th		17. Father's Name (First, Middle, La	2			Cosm	netologist 18. Mother's Nam	ne (Firet Middle	Maidan Sı		netology
ntal Fed ot	Be	• • • • • • • • • • • • • • • • • • • •	Martin C.F. Schr	noor.			10. WIGHTER STRAIT		Emma N	•	
should nd Me mark matic	욘	19a. Informant's Name/Relationship			19b. Mailing	g Address (Stree	l t and Number or Ru				Zip Code)
nd 2 salth an 27 is		Beverly Fischer S	Shelly / Daughter			3	315 Somerset A	Ave. Cambr	idge, Ml	D 21613	
ss 1 a of Height		20a. Method of Disposition		20b. Plac	e of Dispos	sition (Name of natory or other pla	ace)	Date	20c. Loca	tion - City or	Town, State
Page nent ant: If ury o		1 X Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (<i>Spe</i>	ecify)	Easterr	n Shore V	Veterans Cen	netery 2/2	2/2009		Hurlo	ck, MD
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. In the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once.		21 Signature of Funeral Service Li	PL			Name and Addre					
<u>20</u> = 20		Marie y fell		luea						St., Cam	bridge, MD 21613 Approximate
		23a. Part1. Enter the disease, or conshock, or heart failure. List of Immediate Cause (Final	nly one cause on each lii	ne.							Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a. Sever	e i	25 ev	domens.	renous (0114(7			
Examiner		1	Acut	e 12	Lena	e fo	ailure				
	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as							- 1	
e executed lian and urial-transit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c								
be exection a		resulting in death) Last	Due to (or as	a consequer	nce of):						
rificate be ex ng physician a	dica	•	d								
n certifi anding use as	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	pf pregnanc	y				230	d. Date of de	livery
or atte	Physician/Medica	in the past 12 menths?	1□Live birth 4□Pregnant a			Ectopic pregnand Other <i>(specify)</i> _	cy			Month	Day Year
that the de led by the	hys	9 Unknown	9∐Unknown								
res tha igned be def	by P	Part II. Other significant condition	s contributing to death b	ut not resulti	ng in the un	iderlying cause gi	iven in Part I.				the cause of death?
w require been sign								1 🗆 '	Yes 2	4¶o 3∐P	robably 4 Unknown
e faw i has be	Completed							24a. Was autor	osy 💄	24b. Were a prior to death?	utopsy findings available completion of cause of
	ပ္ပြဲ		.,					1□ Yes	rmed2 2 ☐ No	1 ☐ Yes	2 DH6
Physician: Tr this certificat	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	2005	7/Outnotion	t 3 DOA Ot		ath (Check only o		T011 (0	
Physer this eral di	5 : T	27. Manner of Death	28a. Date of Inju	ıry 2	8b. Time of	28c. Inju	ther: 4□ Nursing H ury at	28d. Describe			эспу)
nding I th. r: After e funer	tior	1 ☐ Hatural 5 ☐ Pending 2 ☐ Accident investiga	(Month, Da	y Year)	Injury		ork?]Yes 2∐No				
Arte er dea rector by th	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ad [26e, Place of In]	ury - At home	e, farm, stre	eet, factory, office)	28f. Location (3 City or Tox		Number or R	ural Route Number,
Ital or ris after ral Dil	Cer										
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica	Medical		Physician: To the best xaminer: On the basis of and manner st	of examinatio							
To the within To the	Me	29b. Signature and title of certifier	DI. H				nse number		29d. Date	signed (Mon	th, Day, Year)
		Jan	MY MO				47924	t l	1.3	30.00	î
		30. Name and address of person w		death (Item 2	3a) (Type, I				0.	c ,	10 21613
		31 Date filed (APPRIT PRIVILED)	1+4~WY	rar's Signatu	0 5	BYRN)) /	C 1211/1/C	1961	<i>y</i> /-	10 4613
St Regist	ate	31. Date filed (Month, Day) Year)	and Brain	rar's Signatu	pa	Med					

ORIGINAL

DHMH 17 Rev 1/2001

			For	State of Mary				Mental Hy	giene		00057
			Registrar 1. Decedent's Name (First, Middle, L	ast)	Cei	rtificate of l	Jeath	2. Date of De	Reg. No. 2	109	3. Time of Death
100	Physicia /Medic	al	Robert Du	ll		4.07.7		Month O (Day Z-8	Year	5:20 PM
fee:	Examin	er	4a. Facility Name (If not institution, g Future (are 1) 5. Social Security Number 6.	Parth Point	ı yrs. last birthday)	4b. City, Town, or Dunda If Under 1 Year	Sle, If Under 24 Hrs	UD	4c. County	Him	ne
Di	uneral irector		213-42-3252 Usual Residence of Decedent	1X M 2□F	66 Yrs.	Months Days	Hours Min	(Month, Da	21,1942	Cour	place (State or Foreign htry) ryland
yłand	at		10a. State 10b. County	10	c. City, Town or Lo	ocation				1	0d. Inside City Limits
e Mai	3a-f sl	ctor	Maryland N/A		Bal	timore					1 XYes 2 No
vith th	or 28	Dire	10e. Street and Number	1 4		10f. Zip Code			10g. Citizen of \	What Cour	ntry?
death with the Maryland	ns 23e	Funeral Director	430 Patterson Par	12. Was Decedent Ever	in 11 S 12 S	212		Pacifu Vac or No	USA 14 Bac	e - Americ	an Indian
21215-0036 ad within 72 hours after dogene.	ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 🎉 No	Specify:	to Rican, etc.)		ck, White,	
ام م <u>را</u>	"natu dical	etec	15. Decedent's i (Specify only highest g	Education rade completed)	16a. Dece	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of wo	orking	16b. Kind of B	usiness/In	dustry
Maryland 2121 12 should be filed within h and Mental Hvoiene.	than he Me	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)	1	borer	"		Pogue	line	Company
Elled N	other ent, t	Be Co	17. Father's Name (First, Middle, Las	st)		DOLGI	18. Mother's Na	me (First, Middle			Сопрану
Maryland nd 2 should be file lith and Mental Hy	rked tic ev	To B	Robert Aull Sr.				Theodat	te Baile	V		
any	is ma auma		19a. Informant's Name/Relationship	(Type. Print)	19b. Mailir	ng Address (Street	and Number or A	ural Route Numb	er, City or Town,	State, Zip	Code)
ealth	Important: If Item 27 is marke any injury or other traumatic once.	ī	Lisa Aull, Daugh		705 S	outh Grun	dy Stree				
Jor H	or of		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	Theirioval from State		osition (Name of matory or other place	i i	Date	20c. Location -	· City or To	own, State
Baltimore,	Important: any injury once.		4 □ Donation 5 □ Other (Spec		letro Cre	matory In	c. 102/()5/09	Baltimo	ore,	Maryland
Balt permit.	any ir		Thomas Gregor	Tiy-	C	remation 99 Freder	Society	Of Mary	land, Ir	nc.	3 21222
Phy	sician		23a. Part1. Enter the disease, or co shock, or heart failure. List online disease or condition	mplications that caused the	death. Do not ent	ter the mode of dyin	g, such as cardia	c or respiratory a	orrest,	yran	Approximate Interval Between Onset and Death
	edical miner		resulting in death)	Due to (or as a co	nsequence of):			y 0.1 ()			
10	minei	_	Sequentially list conditions,	b	HS1	WD					
pet	nsit	Examiner	Sequentially list conditions, transplaced by commediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or se a so	печинетоту.						
), execu	n and ial-tra	Exar	that initiated events resulting in death) Last	c Due to (or as a co	nsequence of):			·			
8760, cate be executed	physician and the burial-transit	dical		d							
c 68	ng ph e as th	Medi	IF FEMALE:								
. Box 6	attending p	ian/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf p 1 ☐ Live birth 2 ☐	Fetal death 3	⊒Ectopic pregnancy				te of delive	ery Day Year
G. ege	ed by the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time 9□Unknown	e of death 5	Other (specify)			1010	211111	Day
□	deta	Completed by Physician/Me	Part II. Other significant conditions	contributing to death but no	ot resulting in the u	nderlying cause give	en in Part I.	23e. Did t	tobacco use cont	tribute to tl	ne cause of death?
ords, P	s been signed to should be det	d b						10	Yes 2 □ No	3 Prot	pably 4 Dunknown
Records,	2 sho	plete						24a. Was	an 24b.	Were auto	psy findings available
E PE	page 2 s	mo:						auto perfo 1□ Yes	ormed?	prior to co death? 1 ∐ Yes	mpletion of cause of
or Vital Physician: T	rthis certificate ral director, pag	Be (25. Was case referred to medical examiner?				26. Place of De	ath (Check only o			
2 >	.છ ≔ ⊟	၉	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 Inpatient 28a. Date of Injury	2 ER/Outpatier		4 Le Triursing I	Home 5 ☐ Resi			y)
Division or it or Attending Physafter death,	After	tion	1 ☑Natural 5 ☐ Pending	(Month, Day Ye	ear) 28b. Time o	Worl	yat ⟨? Yes 2 □ No	28d. Describe	how injury occur	red	
vision Attending	ector.	fica	3 Suicide 6 Could not	be 28e. Place of injury -	At home, farm, str		163 2 140	28f. Location (Street and Numb	per or Rura	al Route Number,
Div al or	od in t	Serti	4 ☐ Homicide determine	building, etc. (S	specify)			City or To	wn, State)		
The Hospital	To the Funeral Director: After th completely filled in by the funeral	Medical Certification:	29a. Certifier 1 Certifying F 2 Medical Ex	Physician: To the best of maminer: On the basis of examiner stated	y knowledge, deat amination and/or in	h occurred at the tin vestigation, in my o	ne, date and place pinion, death occ	e, and due to the curred at the time,	cause(s) and madate and place,	anner as s and due to	tated. the cause(s)
To th	To th	Ň	29b. Signature and title of certifier			29c. License	number		29d. Date signe	d (Month,	Day, Year)
			Am MD			105	7727	-	02/	05	109
1	11/		30. Name and address of person wh	o completed cause of death	(Item 23a) (Type,	Print) than	10/0	1. 1.	0 . 1	41	21271
4	W		31. Date filed (Month, Day, Year)	32. Registrar's		Warm	OVVOVO	100m	a. N	(1)	21634
	Sta Registr		Date med (Morini, Day, Teal)	Sz. riegisitat s	Signature						'
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

nes Chanes A		1- For State Certificate of De	_	_	200	9 0335
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)		Reg. 2. Date of Death	•	3. Time of Death
edical Exami		James Charles Allison,		Month Da January 31,		0 9 50 hrs
		938 Long Cove Road GI	ty, Town, or Location of Death en Burnie		4c. County of Death Anne Arundel	
Funeral Director		216 48 8451 1X M 2 F 60 Yrs.	Under 1 Year If Under 24Hrs. onths Days Hours Min.	8. Date of Birth() 09/20/	/1948 Goi	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene mportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any njury or other transmatic event, the Medical Examiner must be notified at once.	tor	Usual Residence of Decedent 10a. State		140		10d. Inside City Limits 1 Yes 2 X No
	l Director	1614 Furnace Drive	. Zip Code 21060	10g.	Citizen of What Cour	ntry?
	by Funeral	1 Never Married 2 Married Armed Forces? If Yes, si	cedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto I		White, etc.	can Indian, Black, ite
	Be Completed		sual Occupation (Give kind of w f working life. DO NOT use retin		Sb. Kind of Business/I	ndustry
		17. Father's Name (First, Middle, Last) James Charles Allison	18.Mother's Name	•		Seal
		Betty Allison / Wife 1614 Fu	ress (Street and Number or R	Glen Bu	ırnie, Mar	yland 21060
			teran Cem. 02/	05/2009		e, Maryland
Baltimo permit. Page Department o Important: injury or oth			and Address of Facility Go Ritchie Highw	nce Fune ay Balt	ral Servic imore, Mar	e, P.A. yland 21225
Physician /Medical xaminer		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Approximate Interval Between Onset and Death Death				
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death the test of the strength of the Funeral Director: After this certificate has been signed by the attending physician and upletely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated experts resulting in death) last included Due to (or as a consequence of): Due to (or as a consequence of):				
		events resulting in death) Last Due to (or as a consequence of): d. X UNPENDED 23a,PII,2/,28a-f, perME, g888 2/12/09 TT				
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal decedent pregnant at time of death 5 Other	eath 3 Ectopic pregna	ncy	23d. Date of deliver	y Day Year
	by Phys	1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the under	lying cause given in Part I.		occo use contribute to	
	Completed t	hypertension		1 Yes 24a. Was an autopsy performe 1 Yes 2	24b. Were au prior to death?	utopsy findings available completion of cause of
	Be Cc	25. Was case referred to medical 26.Place of Death (Check only one)				
	To B	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3	DOA Other Nursin	g Home 5 Re	esidence 6 🗸 Othe	r: Scene
	ation:	27. Manner of Death Natural Natural Accident 28a. Date of Injury (Month, Day, Year) Fd 1/31/09 Fd 9:40	1 Vac 2X No	28d. Describe how ink	w injury occurred	
	Certification:	3 Suicide 6 X Could not be determined Specify found at home			28f. Location (Street and Number or Rural Route Number, City or Town, State) 938 Long Cove Rd Glen Burnie, MD	
To the Hospital within 24 hours To the Funeral completely filled	Medical	29a. Certifier (Check only one) 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
S D D	Σ	29b. Signature and title of certifier PSCO - PSCO - S	29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) February 1, 2009	
1 79		30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201				
St Regis	ate trar	31. Date filed (Month, Day, Year) FEB 0 6 2009 37 Registrar's Signature	,			
DHMH 17 Rev 1/2	001	ORIGINAL				

09-00799 Krystal Austin Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2009 03359 State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day January 27, 2009 Krystal Lynn Austin 0724 hrs Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harbor Hospital Baltimore N/A 5. Social Security Number If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Funeral Foreign Country) Maryland Min Months Davs Hours Director 29 214 15 0364 05/14/1979 1. M 2 X F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location s 23a or 28a-f show a 1 X Yes 2 No Maryland N/A Baltimore Pages I and 2 should be filed within 72 hours after death with the Maryland nert of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other transmatic event, the Medical Examiner must be notified at once Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 3905 - 8th Street 21225 U.S.A. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, Black, Never Married 2 X Married 2 X No Yes White f Yes, Give Yea Yes 2 X No specify Specify: 2 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 Homemaker Own Home 12th 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Rex Tillman Be Cathy Coffin 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Charles Austin / Husband 3905 - 8th Street Baltimore, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State Date Itimore, crematory or other place) 2 X Cremation 3 Burial Removal from State 02/02/2009 Baltimore, Maryland Bavview Crematory Important: njury or otl Department Donation 5 Other Specify 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service-Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part I. Enter the disease of pomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one caus /Medical Death 1 PER TENSIVE CARDIOVASCUL Immediate Cause (Final disease **xaminer** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and tran Physician/Medical physician the burial -UNPENDED AMENDED Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Day Fetal death Pregnant at time of death Other (Specify) Yes 2 No 9 V Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. ≥ Yes 2 V No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available has been autopsy prior to completion of cause of page 2 performed? death? ✓ Yes 2 1 🗸 Yes certificate To the Hospital or Attending Physician: 25. Was case referred to medica 26. Place of Death (Check only one) Be Other₄ examiner? Hospital: ΠΩΔ Innatient 2 V FR/Outpatient 3 Nursing Home 5 Residence 6 this 1 🗸 Yes ۵ No 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural Yes 2 Pending 24 hours after death. To the Funeral Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c License number O.C.M.E. January 31, 2009 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Margarita Korell MD. Assistant Medical Examiner

Registrar

31. Date filed (Month,

arka

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Woodward Allen **Physician** Marjorie 11:51 AM February 1, 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Co. 7837 St. Bridget Lane Dunda1k If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) June 7, 1936 5. Social Security Numbe 6. Sex 7. Age (In vrs. last birthday) Days Hours Months Min 1 🗆 M 💥 🗓 F 245-52 3264 Yrs. 72 North Carolina Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Dunda1k 1 ☐ Yes 2 No Baltimore Director Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21222 United States 7837 St. Bridget Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 같철No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify Specify. ģ White 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Verizon Telephone Operator Years Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nettie K. Ledford Frank Leon Woodward ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20779 19a. Informant's Name/Relationship (Type. Print) 6386 Old Solomons Island Road Tracys Landing, MD Melanie Bushee (Daughter) Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 2/6/2009 4 Donation Trinity Mem. Gdns Waldorf, Maryland 21. Signature of Puneral Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease or complications that caused the shock, or head failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) structive Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 Other (specify) ☐Yes 2 No 9 Unknown 9 DUnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 □No 1 ☐ Yes 2 互 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 300 Other: 4 Nursing Home 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 5 Residence 6 Other (Specify) 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Bescribe how injury occurred 1 Natural 2 Accident 1 □Yes 2 □ No

the Hospital or Attending Physician: The law requires that the death certificate be exeruted burial-tran Division of Vital Records, P.O. Box 68760, attending physician for use as the buria been signed by the should be detached Medical Certification: To this

Funeral

Director

show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Invition I Eval. in a must be notified any Injury or other traumatic event, the Invition I and Injury or other traumatic event, the Invition I and I and I and I and I and I and I are a mart by notified I and I are a mart by notified I and I are a mart by notified I are a mar

Physician /Medical

Examiner

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

with the Maryland

within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral.

3 ☐ Suicide 4 Thomicide 29a. Certifier (Check only one)

29b. Signature and title of certifier

5 Pending investigation 6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Junta 313

Prtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

Billine Mary bot 2(204

and address of person who completed cause death (Item 23a) (Type, Print)

- yanles Street ORTH

29c. License number

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 9 For State Registra Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death ^{Day}, 2009 Physician February 8:34 A M Sidney Edward Alley /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Harford Memorial Hospital Havre de Grace Harford If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**⊠** M 2□ F Months Days Hours Yrs. Director 229-28-1578 Virginia Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits th and Mental Hygiene. If is marked other then "natural", or items 23s or 28s-f show traumatic svent, the Medical Examinat must be taxified at 1 ☐ Yes 2 No Directo Maryland Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3725 Washington Avenue 21009 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Compl Elementary/Secondary (0-12) Coltege (1-4or 5+) U.S. Government Mail Carrier 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filt Depertment of Health and Mental Hy Important: If Itsm 27 Is marked oth any liqury or other traumatic avann DRB: 17. Father's Name (First, Middle, Last) Be Leanna (nmn) Shockley Sebert (nmn) Alley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3725 Washington Ave., Abingdon, MD 21009 Lula Earlene Alley / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Monta Vista Mem. Gdn. 2-7-09 Galax, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. ley 1317 Cokesbury Rd., Abingdon, MD 21009 usa 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in its and avents. Due to (or as a consequence of): The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) $\mathcal{J}/\mathcal{S}/\mathcal{O}\eta$ ital Records, P.O. Box 68760, Medical Certification; To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No 2 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 Inpatient 2 FVOutpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 □ No this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending death. 1 ☐ Yes 2 ☐ No i Director: A d in by the fr 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Momicide within 24 hours a
To the Funaral C 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
RADAGOPALA RAO TRIPURANENI, MD

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year) FEB 0 6 2009 32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2009 February 5:00 PM Mir Mohammad Akbar /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery General Hospital Mongtomery Olney If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☑ M 2 □ F Days 1925 Afghanistan Director 84 January 214-08-2185 Usual Residence of Deceden the Maryland 10d. Inside City Limits 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 33a bandined a lary or other traumatic event, Item Radical Extra inc. 1981 bandined at Jry or other traumatic event, Item Radical Extra inc. 1981 bandined at 10a. State 10b. County 1X Yes 2 □ No Director Olney Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 20832 Afghanistan 18611 Olney Mill Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: Caucasian Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accountant Accounting 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown ပ Mir M. Hassan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kabir Atayee - Brother-in-law 18133 Hayloft Drive Rockville, Maryland 20855 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of h Important: If ite any Injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State National Memorial Park Feb. 5, 2009 Falls Church, Virginia 5 ☐ Other (Specify) 4 Dopat 21. Signature of Funeral Service Licens 22. Name and Address of Facility Jefferson Funeral Chapel 5755 Castlewellan Dr. Alexandria, VA 22315 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** THEROSCLEROTIC VEARS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal deat 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: The law requires that the de 24 hours after death.
Funeral Director: After this certificate has been signed by the etely filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 Urrobably 4 ☐ Unknown Completed ENAL 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 No 2 □ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Mann Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifier 00 3 and address of person who complete cause of death (Item 23a) (Type, Print) HERR 18101 M JOHN 31. Date filed (Month, Day, Registrar's Signatur 32 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma			tment of F ificate of		ı wenta	aı mygı Re	ene g. No. 20	09	03363
dqd-	Physicia	an	1. Decedent's Name (First, Middle, La	,	WALTER		ALLEN		Mo	e of Death nth	Day	Year	3. Time of Death
No. of Street, or other Persons	/Medio	al	4a. Facility Name (If not institution, giv		WHILL	4		r Location of Dea	FE	B. 4	200 4c. County		5:50 A ^M
and the same	LXdiiiii		CARROLL HOSPI	CE DOVE I	HOUSE			INSTER			CAR	ROLL	
ì	Funeral Director		5. Social Security Number 6. S 17 - 09 - 5 3 7 7	ex 7.Age ★M 2□ F	e (In yrs. last birt 89		If Under 1 Year Months Days	Hours Mi	n. (Mo	e of Birth onth, Day, 2/19	<i>Year)</i> 1 9	Cour	place (State or Foreign of try) YLAND
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Loca	tion					1	0d. Inside City Limits
	Maryla	tor	MD CARRO	LL			STER						1∭Yes 2☐No
	or 28a	Director	10e. Street and Number				10f. Zip Code			10	g. Citizen of	What Cour	ntry?
	s 23a		505 HIGH ACRE	, Apt.		1.5 111	2115		(D '')		USA		1
980	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or items 23a or 28a-f show event, the "vedical Evertine must be reoffied at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 X Yes 2 ☐ N If Yes, Give Year or Dates: √	Мо		as Decedent of F es, specify Cuba ∃Yes 2 X No	Hispanic Origin? an, Mexican, Pue Specify:	(Specify Ye erto Rican,	etc.)		ce - Americ ck, White, y: WH]	etc.
2-0	72 hor	eted	15. Decedent's Ed (Specify only highest gra	lucation ade completed)	16a.	(Give kir	nt's Usual Occup nd of work done	durina most of w	vorking	1	6b. Kind of B	usiness/In	dustry
21215-0036	within iene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+) A		NOT use retired STANT 1	a) FOREMAN	1	l _M	IANUF <i>A</i>	ACTUE	RING
ام 1	other vent, t	Be C	17. Father's Name (First, Middle, Last,)				18. Mother's N					
Maryland		To E	ТНОМА	S WALTER									BINSON
Mar	s 1 and 2 should if Health and Mer Item 27 is marke other traumatic		19a. Informant's Name/Relationship (^{Code)} 21157
	s 1 and of Heal item 2 other		RUTH L. ALLEN 20a. Method of Disposition	- WIFE			ion (Name of tory or other place	RE, APT	Date		Oc. Location		
Baltimore,	6 C = 5		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Ponation 5 ☐ Other (Specif		SOUTH C			12/	7/09	,	WINFI	ELD,	MD
3alti	permit. Pag Department Important: any Injury o		21. Signature : Tunora Service Licer	isee	SUUIN C	22. 1	Name and Addre	ss of FacilityF I	LETCH				DME, P.A.
	σ□ = σ ο		23a. Part1. Enter the disease, or com	plications that sauced	the death. Do n	-						R, MI	21157 Approximate
	Physician		shock, or heart failure. List only Immediate Cause (Final	one cause on each lir	ie.			In Br		alory arre	J.,		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a Due to (or as	a consequence o		7 - 510 1	1-1-1	-)			_	Hear
	Examiner	<u>.</u>	Sequentially list conditions,	b		0							
. X	uted Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter the arrival Cause (Disease or injury that initiated events	Due to (or as	a consequence o	ot):							
68760, ₁ 2	tificate be executed g physician and as the burial-transit		that initiated events resulting in death) Last	Due to (or as	a consequence o	of):							
876	cate be ohysici the bu	edical		d									
			IF FEMALE:	23c. If yes, outcome	of pregnancy						23d Da	te of delive	erv
P.O. Box	The law requires that the death cer ate has been signed by the attendir bage 2 should be detached for use	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death t time of death		Ectopic pregnanc Other (specify) _	ÿ			1	onth	Day Year
	es tha igned be det	by P	Part II. Other significant conditions of	ontributing to death be	ut not resulting in	the unde	erlying cause giv	en in Part I.	23				ne cause of death?
Records,	w requir been s should I	eted							-	1 □ Ye:			oably 4 Unknown
_	sician: The law certificate has t rector, page 2 s	Completed							-	a. Was an autopsy perform ⊒Yes 2	ed	Were auto prior to co death? 1 Yes	psy findings available mpletion of cause of 2 No
Vital	s certif	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ent 2 ER/Out	toationt	2□ DOA Oth	26. Place of D			,	201 (0	WHospice
סָר	ig Phy ter this neral d	n: T	27. Manper of Death	28a. Date of Inju	ry 28b. T	<u> </u>	28c. Injur	y at			v injury occur		Mospice
Sior	tendin eath. or: Af the fur	catio	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b	1			M 1□	Yes 2 □ No					
Division of	l or At after d Direct I in by	Certification: To	4 Homicide determined	28e. Place of Injubulgh	ury - At home, far c. <i>(Specify)</i>	m, street	t, factory, office			cation (Str y or Town,		ber or Rura	al Route Number,
	To the Hospital or Attending Physician: white 24 hours after deals. To the Funeral Director: After this certifica completely filled in by the funeral director, to	Medical C		nysician: To the best on niner: On the basis of and manner sta	f examination and								
	To th within To th comp	Me	29b. Signature and title of certifier	Dr. My	wo		29c. Licens	e number 059 a 4	3	29	d. Date signe	ed (Month,	Day, Year) 5/7009
	3+1		30. Name and address of person who		eath (Item 23a) (Type Pri	int) Sur	e 307	we	Shai	nsper	M	71157
	Sta	te	31. Date filed (Month, Day, Year)	32 degistr	ar's Signature		<u></u>		Α -	71 /			1 7
	Registr	ar	FEB U 5 20	U9 Cherry	J.	bear	Kel						

Physic /Medi Exami

Funeral Director

	State Registrar	(ate of Dea		Re	200°						
n	1. Decedent's Name (First, Middle, Last) Joseph R. Blackert					2. Date of Death Month February	3 2009	3. Time of Death					
al er	Joseph R. Blackert 4a. Facility Name (If not institution, give street and number)	er)	4b. C	ity, Town, or Locati	on of Death	rebruary	4c. County of D						
	St. Agnes Hospital		Ba	altimore			N	/A					
	212 - 05 - 2561 ¹ XM ² □ F	Age (In yrs. last birth 90 Y	day) If Un Mont		der 24 Hrs. rs Min.	8. Date of Birth (Month, Day, Dec 3, 1	9. 1 918 M	Birthplace <i>(Stat</i> e or Forei Country) aryland					
	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location					10d. Inside City Limi					
to	Maryland Baltimore	C	atonsv	ville				1 □ Yes 2 1 N					
irec	10e. Street and Number			Zip Code		100	g. Citizen of What	Country?					
a a	505 South Rolling Road			21228			USA						
nne	11. Marital Status 12. Was Deceder Armed Forces	at Ever in U.S.	13. Was De If Yes, s	cedent of Hispanic pecify Cuban, Mex	Origin? (Speican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - A Black, W	merican Indian,					
be completed by runeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ X Yes 2 ☐ If Yes, Give Year or Dates	No 1942		s 2.∭XNo <i>Sp</i> ec				White					
ete	15. Decedent's Education (Specify only highest grade completed)	1 6	Give kind of	Isual Occupation work done during n	nost of worki	ng 16	b. Kind of Busine	ss/Industry					
duc	Elementary/Secondary (0-12) College (1-4o	r 5+)	anager	Tuse retired)			Truc	king					
ပိ	17. Father's Name (First, Middle, Last)			-	other's Name	(First, Middle, Ma							
9 0	Joseph Blackert				Cathe	rine Loe	ffelholz						
	19a. Informant's Name/Relationship (Type. Print)	19b. N	Mailing Addr	ess (Street and Nu	mber or Rura	l Route Number, (City or Town, State	e, Zip Code)					
	Evelyn Blackert, Wife				g Road	Catonsv	ille, Ma	ryland 2122					
	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of D	isposition (/ crematory c	Name of or other place)		ate 20	c. Location - City	or Town, State					
	4 Donation 5 Dother (Specify)	New Cath	edral (ametery	02/0		Baltimor	e, Maryland					
	21. Signature of Funeral Service Licenser Thomas Gregor		²² MacN 301	and Address of Fa Prederic	ra'l Ho k Road	me, P.A. Catonsv	ille, Ma	ryland 21228					
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Ischemic Colitis												
	Due to (or a	s a consequence of)	:					6 weeks					
	Sequentially list conditions, b. Art	heroscler		/ascular	Diseas	е		5 years					
	Sequentially list conditions, if any learning to immediate cause. Enter Underlying Cause (Disease or injury	s a consequence of)											
	that initiated events	s a consequence of)	:										
negical Evalinies	d												
DIMIN	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcom						23d. Date of o	delivery					
25	in the past 12 months? 1 ☐ Live birth 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant	2 ☐ Fetal death at time of death	3 ☐ Ectopi 5 ☐ Other	c pregnancy (specify)			Month	Day Year					
	9 Li Unknown												
medical cel illication. To be completed by Frigsicialin	Part II. Other significant conditions contributing to death	but not resulting in the	ne underlyin	g cause given in Pa	ırt I.			to the cause of death?					
	Parkinson's Disease					1 La Yes	2 % № 3□	Probably 4 Unknow					
2	Sity-Drager Syndrome					24a. Was an autopsy	l prior t	autopsy findings available completion of cause of					
5						performe 1 □ Yes 2							
3	25. Was case referred to medical examiner? 1 ☐ Yes 2 🛣 No Hospital: 1 🛣 Inna			Other:		(Check only one)							
1	27. Manner of Death 1X Natural 5 Pending (Month, D	tient 2 ☐ ER/Outp jury 28b. Tin		28c. Injury at Work?		ne 5 ☐ Residend 8d. Describe how	ce 6 ☐ Other (S)	pecify)					
	1X Natural 5 ☐ Pending (Month, £ 2 ☐ Accident investigation	<i>Day, Year)</i> Inju	iry M	Work? 1 ☐ Yes 2			.,.,						
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of li	njury - At home, farm etc. (Specify)	, street, fact	ory, office	2	8f. Location (Stree	et and Number or	Rural Route Number,					
	Sulfully, (1-1-00.7/				City or Town, S	outo,						
	29a. Certifier (Check only one) 12 Certifying Physician: To the best and manner sent and man	of examination and/	death occurr or investigat	ed at the time, date ion, in my opinion, e	and place, a death occurre	and due to the cau ed at the time, date	se(s) and manner and place, and d	as stated. ue to the cause(s)					
É	29b. Signature and title of certifie		4	29c. License numbe	er	29d	. Date signed (Mo	nth, Day, Year)					
	Xoth to M	D,		DOO40012		Fe	bruary 3	3, 2009					
	30. Name and address of person who completed cause of												
	Scott Poulton, MD, 405 Fr		load,	Suite 204	, Cato	onsville,	MD 212	28					
	=== 0 0 aaaa A	trar's Signature	lande	9									

Sta Registr

State of Maryland / Department of Health and Mental Hygiene 03366 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day /Medical Christine K. Bliss 7:28 AM February 2009 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) **Funeral** Date of Birth (Month, Day, Year) Days Min. Months Hours 1 □ M 2 K F 98 Director 577-05-7876 12/24/1910 VΔ Usual Residence of Decedent show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be reallied at Director 1 ☐ Yes 2 No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12625 Laurie Drive death 1 20904-USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ∐Yes 2 No If Yes, Give Year or Dates: Saltimore, Maryland 21215-0036 ģ 1 ☐ Yes 2 No Specify. 3 N Widowed 4 Divorced Caucasian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Own Home College (1-4or 5+) Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fill and Mental H John Walker King ဥ Lena Noel Marshall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ges 1 and 2 so nt of Health an Barbara C. Bliss/Granddaughter 12625 Laurie Drive Silver Spring, MD 20904-20a. Method of Disposition Pages 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Injury or 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Important: If any Injury or Feb 6 4 ☐ Donation 5 ☐ Other (Specify) Comfort Cemetery Alexandria, Virginia 2009 Signature of Euneral Service Licensee 22. Name and Address of Facility Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, Maryland 20910-23a. Part 1. Enter the disease, or complication that caused the shock, or heart failure. List ally one cause on each line. that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SEPAN resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions lower ones Examiner cause. Enter Underlying Cause (Disease or injury Directo (or as a consequence of): The law requires that the death certificate be executed Dementia and that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-Box 68760. Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Por Day Year 5 ☐ Other (specify) by the a o 9 Unknown 9 Unknown ئە signed t I be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe Division of Vital 2 ∐No 1 ☐ Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 □ Yes Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 2 Accident 1 ☐ Yes 2 ☐ No the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only and manner stated. 29b. Signature and title of certifier 29d. Date sigped (Month, Day, Year) 7 D68096 09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SATYAM SHAH MID SLUER SPRING MO 20910 1800 FOREST GLENKD 31. Date filed (Month, Day, -Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Robert Browns	son,	Jr.

Obert Brownsor	1 _F	I- For State Registrar	or Maryland / De	•	ate of Death		Re	eg. No. 200	9 0336
Physicia Medical Examir		Decedent's Name (First, Middle,Last) Robert	D.		Brownson	ı Jr.	2. Date of Deat Month February 4		3. Time of Death 0320 hrs
Producti Examin		4a. Facility Name (if not institution, give			4b. City, Town			4c. County of Deat	h
		Good Samaritan Hospital			Baltimore	e		201	
Funeral		Social Security Number 6. Sex	7. Age (In y	rs. last birtl			_	th (MM/DD/YYYY) 9. Bi	
Director		215-88-3501 1X	M 2 F 3	5	Yrs. Months [Days Hours	Min. 04	17 73 Forei	puntry) MD
any		10a. State 10b. County	10c.	City, Town	or Location	<u></u>			10d. Inside City Limits
*	۱,	MD NA		Ва	ltimore				1 X Yes 2 No
Aaryland 28a-f show 1 at once.	Director	10e. Street and Number	-		10f. Zip Coo	е	10	og. Citizen of What Cou	intry?
th the Maryland 23a or 28a-f sho notified at once,		1207 Limit Ave				21239	_	U.S.	Α.
be se	Funeral	11. Marital Status 1 Never Married 2 X Married	12. Was Decedent Ever Armed Forces?	in U.S.			in? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Ame White, etc.	rican Indian, Black,
er death			Yes 2 N	10	1 Yes 2 X	No specify:		Specify: B	lack
urs aff	핡	15. Decedent's Education (Specify only	or Dates:		Decedent's Usual Occ	upation (Give k		16b. Kind of Business	
72 ho	턀	Elementary/Secondary (0-12)	College (1-4 or 5+)		during most of working			Donah	5 Defence
003(vithin ene. er tha	Completed	12th grade	2& 1/2 yr	s He	licopter				f Defense
y, MD 21215-0036 and 2 should be filed within 72 hours at teath and Mental Hygiene. tem 27 is marked other than "natural traumatic event, the Medical Examin		17. Father's Name (First, Middle, Last)	G				s Name (First, Middle, M ha Rogers		
212 ild be Menta marke	To Be	Robert Brownsor 19a. Informant's Name/Relationship (Ty		191	. Mailing Address (S			ber, City or Town, Stat	e. Zip Code)
MD d 2 shot of 1 shot of 2 shot of 1	-	Katrina Brownso		8.0	·		Baltimo	•	1239
l and l Health	1	20a. Method of Disposition	2		of Disposition (Name of Dispos	f cemetery,	Date	20c. Location - City o	r Town, State
more Pages 1 ent of F nt: If i		1 X Burial 2 Cremation 3 Donation 5 Other Specify:	Removal from State		uid Ridg	e	2/10/09	Pikesvil	le, Md
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med	1	21. Signature of Funeral Service Licens	9 /		22. Name and Add March F				
		Tala IV	arin	/	14300 Wa	bash A	ve, Balt	imore, Md	
Physician li l		23a. Part I. Enter the disease, or complifailure. List only one cause on each	h line.				ardiac or respiratory arre	est, snock, or neart	Approximate Interval Between Onset and
xaminer			lypertensive Athero		Cardiovascular	Disease	55.0		Death
familia and a second		Sequentially list conditions, b.	ao to (or ao a concequen	00 0.).		- 3			
	iner	if any, leading to immediate D	ue to (o r a s a consequen	ce of):					
	Examiner	(Disease or injury that initiated C.—	ue to (or as a consequen	ce of):					1
scuted and transi		d							
be exe	Medical	UNPENDED	AMENDED						
760, ficate be g physici		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of	pregnancy	Fatal death	2 Ectonic	pregnancy	23d. Date of delive Month	ry Day Year
Box 687 e death certific the attending p	Ciar	past 12 months?	4 Pregnant at time	of death 5	Fetal death Other (Specify)	3LCtopic	, pregnancy	Monar	Day Teal
Boy e death the att	Physician/	1 Yes 2 No 9 Unknown	g Unknown						
2.O. Box 68760, that the death certificate be executed red by the attending physician and detached for use as the burial - transit	by P	Part II. Other significant conditions	contributing to death but i	not resulting	g in the underlying cau	se given in Pa		obacco use contribute to	·
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r Atte	lical	2 Accident Investigatio 3 Suicide 6 Could not b	28e Place of Injury -	At home, fa	arm, street, factory, off	ce building, etc			tural Route Number, City
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Division of Vital Records, P.O. Box 68760, To the Hospital or Arteriding Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		(or only	n: To the best of my known						
To To To To To To To To To To To To To T	Medical	2	and manner stated.			cense number		29d. Date signed (M	
	-	Pat	1200 L.	~		.C.M.E.		February 4, 200	
	-	30. Name and address of person who co	ompleted cause of death	(Item 23a)					
		Patricia Aronica-Pollak MD			niner 111 Penr	Street, Ba	ltimore, MD 2120	1	
	ate	31. Date filed (Month, Day Year) FEB 0 5 200	32 Registrar's Sig	gnatur	parked				
Regist	ar	1 LD 0 0 200	O Partie Partie De De De De De De De De De De De De De	1000	1000				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item I per doc g888 2-17-09 vt. State of Maryland / Department of Health and Mental Hygiene Reg. No 2009 03368 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dorothy I. Bily February Dorothy T 04:45 A M **Physician** 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore The Wesley Home Trunder 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Month, Day, Month, M 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** West Virginia 234-30-7798 1 □ M 2X F 89 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 28a-f show other traumatic event, the Medical Examiner must be notified at 1 □Yes 2XXNo Director Maryland Baltimore Parkville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2707 Glendale Rd. 21234 U.S.A. 23a Funeral items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. 1 □Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 ☑ No Specify: þ Specify: White 3 ₩ Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) filed within I Hygiene. Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry Roberts Wilsie Thompson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3309 Megans Way, Olney, Maryland 20832 Anita Goeller - Daughter permit. Pages 1 and Department of Healt Important: If item 27 any Injury or other 1 once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Moreland Mem. Park 2/6/2009 Parkville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services - Parkville 8800 Hartord Rd. Parkville, MD 21234 Fuperal Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart siliure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine CARDIO MY Due to (or as a consequence of) burial-transit and Box 68760. attending physician for use as the buria requires that the death certificate be DISHAGE Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day Year signed by the a Ö 9 Unknown ₫. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 INSUFACIENCY CHRONIC RENAL 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsv performed? Yes 2 XNo THROMBOPHLL-BITTS KECURRENT 1 ☐Yes 2 ☐ No 1 □Yes ial or Attending Physician: 's after death.
In Director: After this certification by the funeral director, p Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 5 ☐ Pending investigation 1. Natural 1 □Yes 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide within 24 hours a

To the Funeral D Hospitai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed

31. Date filed (Month, Day,

E-

Year)

0 6 2009

W. ROGERS AVE-BALTO-

cause of death (Item 23a) (Type, Print)

M.D. - 2211

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registrar Certificate of Death Day the Zoog 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Marilyn Month Krooks 5:40 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Scasms Hospice - Northwest If Under 24 Hrs. Hours | Min. Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Funeral 1 □ M 2 🔀 F Months Days MD Director OT/18/1944 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 'natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at MD Baltimore Director 1 Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Rosedale. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo þ Specify: Specify: Back 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "any Injury or other traumatic event, the Megone. College (1-4or 5+) Elementary/Secondary (0-12) Decords 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bractor George seneva ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Avenue Baltimore MD 21207 Mov garet 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ■ Burial 2 □ Cremation 3 □ Removal from State Baltimore, MD 02/09/09 4 □ Donation 5 □ Other (Specify) Arbutus Memorial Park 21. Signature of Funeral Service Licens 22. Name and Address of Facility Voughn C. Greene Fungral SKS - Read Randallstown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, of heart jailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Atherosciorot /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in ilitated events resulting in death) Last Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical as IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Feta! death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year signed by the at d be detached fo 5 ☐ Other (specify) 1 □Yes 2 X No 9 Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24a. Was an autopsy performed? 1 □ Yes 2 🎾 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ☒No within 24 hours after death.

To the Funeral Director; After this certificate has completely filled in by the funeral director, page 2 s 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specific 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H45931 Burtan 4. 2009

Registrar

DHMH 17 Rev 1/2001

State

varke

2835 Smith Avenue Sute 203 Baltimore, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Burton

06

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** BROWN 0811 A M VERNICE January /Medical Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** NORTHWEST HOSPITA Rundallstown Baltimone Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** Months 50 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA isa Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any Injury or other traumatic event, Item Medical Examples. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) tyears Be Pernell Brown ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number ane Randallstown, Mb 21133 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State aun Cemeley 2/1/09 Woodlawn, MD
22. Name and Address of Facility valuation C. Greene funeral Sives odlaun Cemeter 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 8728 Liberty Rd. Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atheroscipeotic Coronary Vasculur Physician Hyper /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the death certificate be executed signed by the attending physician and be detached for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, mellitus BETES cate has been si, page 2 should b 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed Hyper cholesterolemia 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, page 1 ☐ Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0057634 2609

State Registrar 5401

MD

32. Registrar's Signature

Old Court Road Randallstown, MD 21133

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Brand

Christine

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 0 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician hicks Brown Year 1710 99 Fobruar /Medical 200 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death west HOSPICE Baltimore If Under 1 Year 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 12/1/1968 **Funeral** 1 □ M 2 Months Days Min 217-02-7282 **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or items 23a or 28a-f show 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, traincrime in ust be notified and once. Baltimore Funeral Director ₩es 2 No 10e. Street and Number 10g. Citizen of What Country? 5039 Alameda 21239 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hep IVIS KtG mens whrehouse 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4907 The Alamedy Baltimore, MI) 21239 Johnson 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2.6.2009 Bultimore, MI 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joughn C. Greene Foreral Services 4905 York and Bultimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BREAST CANCER disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter or during Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 No 23d. Date of delivery 3 🗆 Ectopic pregnancy 4 Pregnant at time of death Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 N Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ➡ No 24a. Was an autopsy performed? 2 🔼 No 2 No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☑ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Olmer (Specify) MOSPICE 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🖍 Natural 5 Pending investigation Injury 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

Physician /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit P.O. Box 68760, of Vital Records, Division

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

State Registrar 31. Date filed (Month, Day,

(Check only one)

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

1445931

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

835 SMITH AVENUE SUITE 203 Baltimore MOZIZOS

			1- State of Maryland / Department / Department / Departmen	artment of Health and Me rtificate of Death		ene 2009	03372
	Physici /Medi	cal	Decedent's Name (First, Middle, Last) Eva Thelma Dillard Bridges		2. Date of Death Month anuary 2	Day Year	3. Time of Death
	Examir Funeral	ner	4a. Facility Name (If not institution, give street and number) 7316 Sandia Court 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	4b. City, Town, or Location of Death Greenbelt If Under 1 Year If Under 24 Hrs. 8	3 Date of Righ	4c. County of Death	-l (C) 5
	Director		241-42-5368	Months Days Hours Min.	B. Date of Birth (Month, Day, Y	.1927 Eden	place (State or Foreign intry) N.C. (Leaksville
	r 28a-f sho	rector	Joseph Grand Grand	10f. Zip Code	100	. Citizen of What Cou	10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	r death witt tema 23a o er must be	Ineral D	7316 Sandia Court 11. Marital Status 12. Was Decedent Ever in U.S. 13. Yarmed Forces?	20770 Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto Ric	Un:	ited State	S can Indian,
-0036	2 hours afte atural', or it	ed by Fu	1 Never Married 2 Married 1 Yes, 2 No If Yes, Give Year or Dates: 15. Decedent's Education 16a, Deced	1 ☐ Yes 2√ No Specify:		Specify: B1a	ack
21215-0036	filed within 72 hours after death with the Maryland Hygiene. sthar than "natural", or Itema 23a or 28a-1 show ant, tre Malical Examilinar must be notified at	Completed by Funeral Director	(Specify only highest grade completed) Elementary/Secondary (0·12) Twelve College (1-4or 5+) Regis	tered Nurse	C	b.Kind of Business/In ity of ew York	dustry
Maryland	should be fill of Mental H marked oth	To Be		18. Mother's Name (FElizabeth	Hampton		
	is 1 and 2 soft Health are itam 27 is other trau		Yvonne Alston/Niece 1001 20a. Method of Disposition 20b. Place of Disposition		e,Largo	ity or Town, State, Zip MD 20774 : Location - City or To	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural", or itema 23a or 28a-f show any injury or other traumatic event, it a Modical Examilinat must be notified alongs.		*4 Donation 5 Other (Specity) Eden Gard 21. Sign fur of Funer Service Is used	ens Cemetery 2009 Name and Address of Facility Rober 61 Good Hope Rd SE,	y 30, Ed	en, North son Funera	Carolina
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not ente shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	or the mode of dying, such as cardiac or reachial Infance	espiratory arrest,	gton bc 20	Approximate Interval Between Onset and Death
	Examiner	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
8/60,	icate be executed physician and s the burial-transit	ai Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):	a	-		
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P.O. B	t the c by the achec	Physician/M	1 ☐ Yes 2 No 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown	Ectopic pregnancy Other (specify)			Day Year
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H.	The far ate has page 2	e Completed	25. Was case referred to medical		24a. Was an autopsy performad 1 Yes 2 X	prior to con death?	osy findings available inpletion of cause of
5	ng Phys Iter this	on; To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 EP/Outpatient 27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year)	To the state of th	4.0	6 □Other (Specify)
DIVISION	or Attan after deat Diractor: I in by the	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, farm, streed building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No et, factory, office 28f.	Location (Street City or Town, St	and Number or Rural ate)	Route Number,
	the Hospit hin 24 hour the Funara npletely fille	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or investant manner stated.	occurred at the time, date and place, and satigation, in my opinion, death occurred a	due to the cause at the time, date a	(s) and manner as sta and place, and due to	ited. the cause(s)
	To With	-	29b. Signature and fittle of cartifles	29c. License number	29d. [Date signed (Month, E	2009
0	√√ Stat	e_	31. Date filed (Month, Day, Year) 32. Registrar's Signature	enway Center 1 #	316 Gree	enbett, Mil	20170
	Registra	ar	FEB 0 6 2009 Lender S. Jan	led			

Amend #17, per FH g888 2/11/09 TT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 03373 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 2009 1455 Anna Heinrich Burrows February 3 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 ☐ M 2 💢 F Director 212-64-6359 95 December 28, 1913 Washington D.C. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ed other than "natural", or items 23a or 28a-f sho event, the Medical Exemirer must be rectified at 1 ☐ Yes 2 No Director Kensington Maryland Montgomery 10e. Street and Number 10g. Citizen of What Country? 20895 United States 9634 Culver Street Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 📉 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and 2 should be Charles : Heinrich Annie Cogswell 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health 9634 Culver Street, Kensington, Maryland 20895 William C. Boyd/Nephew 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of the Important: If Ite any Injury or ot once. February 7, 1 → Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Parklawn Memorial Park 2009 Rockville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. thist M01360 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory armst, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiac Arrest /Medical Due to (or as a consequence of) Examiner Atrial Fibrillation Sequentially list conditions, if any, leadin, to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit Proctitis Due to (or as a consequence of) O. Box 68760. Physician/Medical Bilatera Pleural Effusion IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death signed by the a 5 Other (specify) 9 Unknown 9 T Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ₫ Intertrochanteric Fracture of Left Hip Status Post 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? Repair 24a. Was an has certificate 1 ☐ Yes 2 🕅 No 2 □ No Division of Vital 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🔀 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) January, 10, 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred the Hospital or Attending 5 Pending investigation 1 Natural 5:00 A M Slipped and fell 1 ☐ Yes 2 🖾 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
At Home 28f. Location (Street and Number or Rural Route Number, 96347 CW1\text{Ver} Street Kensington, Maryland 20895 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) SUBARSHAN SOVA 765312 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Road, Bethesda, Maryland 20814 Sudarshan Siva M.D. 31. Date filed 32. Registrar's Signature State

Registrar

BURROWS, ANNA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #16a&b Per GH G8882/06/09 JH
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FEBRUARY 3 2009 Physician **BLOCK** 11:55 A M ETHEL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner EMERITUS OF PIKESVILLE BALTIMORE PIKESVILLE Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/09/1925 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛣 F Months Days Hours Min. 83 MD 214-22-9469 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examina: must be notified at Director 1 □Yes 2 No **PIKESVILLE** MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 3204 OLD POST DRIVE 21208 Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or incorrect. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Specify: WHITE If Yes, Give Year or Dates: <u>Ş</u> 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWNER Delicatessen DELICATESSEN **Owner** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JACOB FADEM CECILIA GOODMAN ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 603 OLD CROSSING DRIVE, PIKESVILLE, MD 21208 SANDRA SHAPIRO / DAUGHTER 20a. Method of Disposition Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State RUDOMER VEREIN 02/05/2009 ROSEDALE, MD 4 Donation 5 ☐ Other (Specify) Signature of Puneral Service Liee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Part 1. Enter the disease, or complications that causes the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease Immediate Cause (Final Physician FAITRA CRANT disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed tra resulting in death) Last Due to (or as a consequence of): burial Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) Ö 1 ☐ Yes 2 ☐ Unknown the 9 Unknown signed by the ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an cate has I page 2 s autopsy performed certificate 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred Division Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person whe completed cause of death (Item 23a) (Type, Print) 10 V KERZH 2700 Di Date filed (Month, Day, Year). Registrar's Signat State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 10:24 PM 02 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Memorial Harford 110 Grace Hospita tord Hwve If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) cial Security Number 6. Sex Age (În yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days 1 X M 2 □ F Director 75 22 1933 NORTH CAROLINA 579-38-2509 DEC. Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No Director MARYLAND HARFORD CO ABERDEEN 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 12 NORTHEAST ROAD 21001 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 66/72 1 Never Married 2 Married timore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No 3 ☐ Widowed 4 ☑ Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade NURSING ASST. PERRY POINT MED CNTR 7 is marked other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LUCILLE JENKINS CAMPBELL ပ WILLIAM H. CAMPBELL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) partment of Health a portant; if Item 27 is / injury or other trau William E. Campbell Jr./ Son 1642 N. Harco Dr., Baton Rouge, La., 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 02-07-09 ABERDEEN, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) HARFORD MEMORIAL 21. Signature of Funeral Service big 22. Name and Address of Facility
WILLIAM C BROWN COMM FUNERAL HOME-HARFORD, P.A. Kealen 321 S PHILADELPHIA BLVD, ABERDEEN, MD 21001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** entriumor disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a sonsequence of). been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of): Campbell, Beatrice H800421180 bivision of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performe certificate 1 □Yes 2 No 1 ☐Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1₽Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OU 30. Name and address of per son who completed cause of death (Item 23a) (Type, Print) lfie 01 South 31. Date filed (Month, Day, Year 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1401 M DRTRIGHT /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Annapolis 513 Harbor Dr. If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 □ M 2 🗹 F 61 Director 136-40-9592 Dec 14, 1947 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the "hodical Examinar must be notified at 1 ☐ Yes 2 ☑ No Cresskill Director Bergen 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 07626 27 Milton St. U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) **Legal Secretary County Government** Department of Health and Mental Hygic Important: If item 27 is marked other any injury or other traumatic event, IL once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Cortright Sara Sigel ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Miller Brother-in-Law 6076 Warm Stone Columbia, MD 21045 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 3 Removal from State 1 ☐ Burial 2 ☐ Cremation Feb 05, 2009 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) **Atlantic Crematory** 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 se, or complications that saused the . List only one cause on each line. Approximate Interval Between Onset and Dead 23a. Part 1. Inter the disease shock, or heart failure. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

		Due to (or as a consequence of):	
III III	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as a consequence of):	
Olcar Exar	that initiated events resulting in death) Last	Due to (or as a consequence of):	
INSICIALIVINE	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	23d. Date of delivery Month Day Year
ed by re	Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
			24a. Was an autopsy performed? 1 □ Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
מ	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)
2	1 Yes 2 No		e 5 ☐ Residence 6 ☐ Other (Specify) HVVVI
alloll.	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year) Injury Work? M 1 □ Yes 2 □ No	Bd. Describe how injury occurred
Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	Bf. Location (Street and Number or Rural Route Number, City or Town, State)
calcal		ysician: To the best of my knowledge, death occurred at the time, date and place, ar niner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	
= [/	

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

Year)

6

person who completed cause of death (Item 23a) (Type_Print) an

3. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygione

			1 - For State Registrar	Otate of Ma	Ce	ertificate of		,	0.0	0.0	00077
			1. Decedent's Name (First, Middle, Las	st)				2. Date of De	Reg. No. 2	UJ	3. Time of Death
Н	Physic /Medi		Ann Caro	l Cowman				Month Feb.	5,2009	Year	7:15 A ^M
1	Exami		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, o	or Location of Death		4c. County	of Death	/:13 A
-			llO3 Nicod	emus Rd.		Reist	erstown		R	altim	ore
	Funeral		Social Security Number 6. Si		(In yrs. last birthday	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da	th		place (State or Foreign
	Director		213-32-3701	LIM ALAF	73 Yrs.	Wichitis Days		Dec. 1	8, 1935	Mar	yland
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	neation					
	f sho	ō								10	Od. Inside City Limits
	28a-	Director	MD Baltin	nore	Reiste	erstown					1 ☐ Yes X2X No
	with ga or					10f. Zip Code			10g. Citizen of V		•
	leath ns 23	Funeral	1103 Nicoden	NUS RO • 12. Was Decedent Ev	ver in LLS 12		21136	16.34		S.A.	
က	fter o	Ē	1 ☐ Never Married 2 Married	Armed Forces?	13.		lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	14. Raci	e - America k, White, e	
<u>0</u>	urs a	þ	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes XXNo If Yes, Give Year or Dates:		1 □ Yes XX No	Specify:		Specify	Wh	ite
5-0	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dign! Evaning must be notified at	Completed	15. Decedent's Edi	ucation	16a. Dece	dent's Usual Occup	oation		16b. Kind of Bu	siness/Ind	ustry
7	thin it	nple	(Specify only highest grad	College (1-4or 5+)	lito	kind of work done DO NOT use retire	during most of worki d)	ing			,
2	filed within Hygiene. ether than "	ပွဲ	11			nemaker			Ow	n Ho	me
pu	be file tral H d oth even	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle,	Maiden Surnam	9)	
<u>ya</u>	should be and Mental s marked of umatic ev	မ	John Charles				Sylvi	a Turn	baugh		
Jar	2 sh n and is m raum		19a. Informant's Name/Relationship (7)	^{ype. Print)} Husba	and 19b. Maili		and Number or Rura				,
e,	l and Health		<u>George G. Cowman</u>	1, Jr./	1103		mus Rd.	Reiste	erstown	, MI	21136
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Worlden Evander must be notified at once.		20a. Method of Disposition XXBurial 2 ☐ Cremation 3 ☐ I	Removal from State	20b. Place of Dispo cemetery, crei	sition (Name of natory or other place	:e)	Date	20c. Location -	City or Tov	vn, State
<u>Ħ</u>	it. Pa rtmer rtant rtant		4 ☐ Donation 5 ☐ Other (Specify,)	cemetery, cree Evergre Gard	ens memo	2/9	/09	Finksh	urg	, MD
Ba	permit. F Departm Importan any Injur		21. Signature of Fundal Service Licens	ee A	2: H	2. Name and Addre	ss of Facility Funeral Ch	anel. F	Ρ.Δ.	12	
			220 Part Enterine standing	and	1 7	1605 Rais	toretown	DA O	in man Mi	lls.	Md. 21117
I			23a. Part 1. Enter the disease, or compl shock, or heart failure. List only o Immediate Cause (Final	ne cause on each line.	e death. Do not ent	er the mode of dyir	ng, such as cardiac o	or respiratory arr	rest,	,	Approximate Interval Between
7	Physician /Medical		disease or condition resulting in death)	a. Chrov	ic ob	structu	e puln	on a	Diser	اعد	Onset and Death
	Examiner			Due to (or as a	consequence of):						
		ē	Sequentially list conditions,	b. Dee to for as a r	lonseyttende of).						
	d d ansit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	(
o,	exectan and rial-tr	Exa	resulting in death) Last	Due to (or as a c	consequence of):						
68760	death certificate be executed e attending physician and d for use as the burial-transit	Medical		d							
9	ng pł	Med	IF FEMALE:								
ROX	leath certific attending p		23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth 2[Ectopic pregnancy			23d. Date	of deliver	v
	e dea he at	sici	in the past 12 months2 1 ☐ Yes 2 ☐ No	4 ☐ Pregnant at tir		Other (specify)	·		Mon	th C	Day Year
7.	requires that the een signed by th nould be detache	Physician/	9 Unknown								
က်	res the signe pe d	þ	Part II. Other significant conditions cor	ntributing to death but r	not resulting in the ur	nderlying cause give	en in Part I.	1	_	oute to the	cause of death?
0	requ	sted	- con jestine	Her > F	tailue			1.246	s 2 □ No 3	I∏ Probal	bly 4 ☐ Unknown
Vital Records,	Physician: The law requires that the dithis certificate has been signed by the all director, page 2 should be detached	Completed						24a. Was ar autops		ere autops	sy findings available pletion of cause of
_ 	i: Th	3						perform	ned? de	ath?	
= =	iciar certif ectol	Be	25. Was case referred to medical examiner?	lospital:			26. Place of Death	(Check only one			
0	Phys rathis	은	1 Yes 2 No Peath	1 Inpatient	2 ER/Outpatien		4 L Nursing Horr				
U .	ding h. After fune	Ę	1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Y	ear) 28b. Time of Injury	28c. Injury Work	ľ	8d. Describe ho	w injury occurred	1	
IVISION	utten deat ctor: y the	lica	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e Place of Injuny	At home form stre		′es 2□No				
<u> </u>	affor affer affer d in b	Certification: To	4 Homicide determined	28e. Place of Injury building, etc. (Specify)	et, lactory, office	21	City or Town	reet and Number n, State)	or Rural F	Route Number,
:	spita hours nera y fille		29a. Certifier 1 Certifying Phys	sician: To the best of n	ny knowledge, death	occurred at the tim	e date and place a	and due to the er	ouss(s) and man		
	Io the Hospital or Attending Physician: The thin 2 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	(Check only 2 Medical Examir one)	ner: On the basis of ex and manner stated	amination and/or inv	estigation, in my op	pinion, death occurre	d at the time, da	ate and place, an	d due to th	ne cause(s)
ř	Vithi To the	Ž	29b. Signature and title of certifier	1 0		29c. License	number	29	9d. Date signed (Month, De	ıy, Year)
			hull	Note	-	0	27123	,	2/5/	24	
4		1	30. Name and address of person who co	mpleted cause of deatl	n (Item 23a) (Type, F	rint)			~()(+	
)			Jodah dringe	we 7	Signature A	A.~ S	+ Ro	·stens.	town	6 m	2113/
	Stat	Ÿ	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	N. B			*		
	Registra		FEB 0 0 200	9 parison	fi. ffa	Colonia Colonia					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens 109 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 2009 12:30 P M Russell Gene Crockett February /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 113xm 2□ F 220-68-9658 51 Director November 3, 1957 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County r 28a-f show notified at 1 ☑ Yes 2 ☐ No Directo Rockville Maryland | Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be r 20851 United States 899 Lewis Avenue Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 □ Never Married 2 N Married 1 ☐ Yes 21 No Specify Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Warehouse Supervisor 7 is marked other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sharon Mason ပ Jackie Crockett, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any Injury or other trau once. 899 Lewis Avenue, Rockville, Maryland 20851 Linda B. Crockett/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) February 9, Rockville, Maryland Parklawn Memorial Park 2009 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. M01548 300 West Montgomery Avenue, Rockville, Maryland 20850 23a. Part1. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SMALL CELL LUNG GANGER NON-Physician SYRS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it my cause in the line of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Due to (or as a consequence of) physician are the burial-t Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an performe 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ★ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Hospital or Attending Physician; The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, within 24 hours after To the Funeral Discompletely filled in

Baltimore, Maryland 21215-0036

8

Medical

State Registrar

THAMBI 31. Date filed (Month,

29a. Certifier

(Check only one)

29b. Signature and

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9707 NEDICHL 32. Registrar's Signature

MD

and manner stated

DR, #300 CTR

29c. License number

D0061083

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

FEB 5,2009

ROCKVILLE, NO 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Month 11:34 PM vatalie Marston Dunlop 2009 1 30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arunde Severna Park Sunrise Severna Park If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 F 88 Yrs. 026-18-6639 12-20-1920 massachusetts Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show 10a. State traumatic event, the Madical Examiner must be notified at 1 Yes 2 No Director WD Anne Ar unde Park 28a-f 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 23a or 21146 USA 6 Tower Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify þ White 3 Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 7 I Hygiene. and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Medica 12 ecretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Marston racker ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If Item 27 Is any injury or other trau SOULRUB PARK WY PAMELA BANNAN DAUGHTER TOWAR 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gifts Registry 1-31-09 Hanover MD 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Tacility ANATOMY GIFTS REGISTEN 21. Signature of Juneral Service License STEP grove CN SUDGAM 7522 COINCLLEY DR. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician a for use as the burial-Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a ☐Yes 2 ☐ No Ö 9 ☐ Unknown 9 Unknown ₫. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>\$</u> 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy page this certificate 2 **N**o 1 □ Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Pother (Specify) 1 | Yes 2 | No Hospital Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After t or Attending 1 Natural 5 Pending after death.

Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D completely filled it Hospitai 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifler 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

4

STE. 100

HOLLY AVE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ari

32.

WILLIAM BEHRENS

EFB 0 6 2009

31. Date filed (Month, Day, Year)

2448

Registrar's Signature

2-2-09

ANNAPOLIS, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Examiner JOSEPH 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In y.s. last birthday 8. Date of Birth (Month, Day, 6. Sex **Funeral** 1□M 2**X**F Min Months Days 120-24-5672 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Expense mark by notified at 1 Yes 2 No Director more 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 212 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced BI ac 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DQ NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ma ၉ 19a. Informant's Name/Relationship (Type. Print) (dughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is 1na lam 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location / City or Town, State 1 Burial 2 Cremation 3 Removal from State Injury 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Address of Facility
L. Rus. 22. Name and Addre P.A. 21216. Jos 23a. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Known /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, for the least conditions, for the least cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of that the death certificate be executed sician and buriel-tran Due to (or as a consequence of): Box 68760, attending physician for use as the burie Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) detached o 9 HInknown 9 Unknown σ. After this certificate has been signed funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 Hospital or Attending Physicien; The law requires 1 Tes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐Yes 2 1 No 2 🗆 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 6 Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending thin 24 hours after co. o the Funeral Director: Aft investigation 1 □Yes 2 □ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richey 838 N Hospice E. ISOMD Bultimare, MD 31. Date filed (Mornth, Day, Year) 32 State

DHMH 17 Rev 1/2001

Registrar

6

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3, 2009 5:45 AM M February Margaret Childs Dawson 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Apex Health of Silver Spring Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
July 23, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Hours Days 1□ M 2X F 91 577-28-6777 1917 Virginia Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Kensington Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3110 Homewood Parkway U.S.A. 20895 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 📉 No Specify: 3X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Banking 12 Mail Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert Franklin Childs Kate Dell Gant 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane D. Boone/Daughter 3110 Homewood Parkway, Kensington, MD 20b. Place of Disposition (Name of cemetery, crematory or other place)
Forest Lawn 20a. Method of Disposition 20c. Location - City or Town, State Date Henrico County, 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 2-6-2009 4 ☐ Donation 5, ☐ Other (Specify) Virginia Cemetery 21. Signature of Funeral Service Licensele 22. Name and Address of Facility Joseph W. Bliley Funeral Home Richmond, VA 23224 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme Te Cau e (Final disease or condition resulting in death) Altheimers Unknown Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐Yes 2 🕱 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? intake 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 反 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 \(\frac{1}{2}\) No fibrillation 1 ☐ Yes 2 ☐ No an emia 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Baltimore, Maryland Physician Examiner Box 68760; P.O.

Physician

/Medical

Examiner

Director

Funeral

Be Completed by

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Examiner

Physician/Medical

2

Be Completed

Certification: To

Medical

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Microal Examiner must be notified at

other t

Department of Important: If it any injury or conce.

/Medical

Physician: The law requires that the death certificate be cate has been signed by page 2 should be detach Division of Vital Records, To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir this

> State Registrar

CHOWDHURY, MD: 15216 DINO DRIVE; BURTONSVILLE, MD20866 31. Date filed (Month, Day, Year) 32. Registrar's Signature 6 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

how dly

1943121

1 - For State Registrar

Physician

/Medical

1. Decedent's Name (First, Middle, Last)

Edward Leonard Decker Jr.

Examin	er	Gilchrist Hospi		Towson					Baltimore				
Funeral			Sex 7	. Age (In yrs. I	ast birthday)			If Under Hours	24 Hrs. 8	B. Date of Bir (Month, Da	th		Birthplace (State or Foreig Country)
Director		084-20-6708	1⊠M 2□F	81	Yrs.	IVIORIUS	Days	Hours		Dec. 3	0, 19	27	New York
, u	. [Usual Residence of Decedent		10- 0:4	. Taura as I a								1404 1
aryla shov	_	10a. State 10b. County		Toc. City	, Town or Lo	cation							10d. Inside City Limits 1 □Yes 2 🛣 No
the M 28a-f	Director	Maryland Harfo 10e. Street and Number	rd	Jo	oppa	10f. Zip	Code				10a Citiz	en of What	
filed within 72 hours after death with the Maryland Hygiene. Hygiene. with artural", or items 23a or 28a-f show ont, the Medical Evanither must be notified at	Ö	438 Haslett Ro	ad				1085				US	_	
death	Funeral	11. Marital Status	12. Was Deced	ent Ever in U.S	3. 13.		dent of H	ispanic Or	igin? (Spec	ify Yes or No		4. Race - A	merican Indian,
after or ite	교	1 ☐ Never Married 2 ☑ Marrie				1 □Yes :		Specify:		can, etc.)		Black, W	hite, etc.
ours iral",	d by	3 Widowed 4 Divorced	Year or Dat	es:				., .,				Specify:	White
"nati	ete	15. Decedent's (Specify only highest			16a. Dece (Give	edent's Usua kind of wo DO NOT us	al Occup	ation <i>luring m</i> os	t of working	7	16b. Kin	d of Busine	ss/Industry
2 should be filed within 72 ho h and Mental Hygiene. I is marked other than "natur raumatic event, in Medical	Completed	Elementary/Secondary (0-12)	College (1-4	4or 5+)		amic					Porce	lain i	Manufacturer
be filed ntal Hygi od other event, I	Be C	17. Father's Name (First, Middle, La			CEI	auuc	Engl		er's Name (First, Middle			Manuracturer
ld be lenta ked ked	To B	Edward Leonard	Decker Sr					Tre	ne (nn	m) Sk	inion	1	
d 2 should th and Mer 7 Is marke traumatic	-	19a. Informant's Name/Relationshi	p (Type. Print)		19b. Maili	ng Address	(Street			Route Numb			e, Zip Code)
alth a		Elaine Decker /	Wife		438	Hasl	ett	Rd.,	Joppa	, MD	21085		
es 1 and 2 of Health of Health item 27 ls		20a. Method of Disposition		20b. P	lace of Dispo emetery, cre				Da				or Town, State
Page nent int: If		1 ☐ Burial 2 ②Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		late	Lltop			i	2-9-0	9	Tows	on, M	aryland
permit. Pages 1 Department of h Important: If ite any injury or of once.	İ	21. Signature i Funedal Service Li	сервее	1 444-	NA.	2. Name ar	nd Addres	ss of Facili		, P.A		•	
88258		Marke 118	my /		1	317 C	okes	bury	Road,	Abing	gdon,	MD 2	1009
		23a. Part 1. Enter the disease, or c shock, or heart failure. List o	omerications that can	used the death	n. Do not en	ter the mod	de of dyin	g, such as	cardiac or	respiratory a	ırrest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition		UNG	PANC	E-R							Months
/Medical		resulting in death)		r as a consequ									11/0111/1/5
Examiner		Sequentially list conditions.	b										
pe #is	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (o	r as a consequ	uence of):								
icate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	c	r as a consequ	ience of:								
be ey ician buria			Due to (o	as a consequ	rence or).								
phys phys the	dic	0.3	d										
th certific ending p	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc	ome of pregna	ncy						2	3d. Date of	delivery
death atter	iciar	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregna	rth 2 🗍 Fetal ant at time of d		☐ Ectopic p ☐ Other (sp					-	Month	Day Year
that the death certificate be executed ned by the attending physician and detached for use as the burial-transit	Physician/Medical	9 Unknown	9 □ Unkno	wn									
es that igned to be deta	by P	Part II. Other significant condition	s contributing to dea	ath but not resu	ulting in the u	underlying c	ause give	en in Part I	l.	23e. Did	tobacco us	se contribute	e to the cause of death?
The law requires ate has been sign bage 2 should be	_	EMPHYSEMA								1028	Yes 2□]No 3□	Probably 4 🗌 Unknow
law re as be	Completed									24a. Was		24b. Were	autopsy findings available to completion of cause of
The I	E O									auto perfo 1 □ Yes	ormed? 2 X No	death	to completion of cause of i? 'es 2 □ No
ician: The certificate ector, pag	Be C	25. Was case referred to medical examiner?						26. Place	e of Death	Check only			00 20.10
hysician: this certific al director,	To E	1 Yes 2 No	Hospital: 1 ☐ In	patient 2 🗆	ER/Outpatie	ent 3 DC	OA Oth	er: 4 🗆 N	ursing Hom	e 5 ☐ Resi	idence 6	Other (S	Specify) HOSPICE
ng F	on:	27. Manner of Death 1 X Natural 5 □ Pending		f Injury n, <i>D</i> a <i>y, Year)</i>	28b. Time o Injury		28c. Injur Work	y at	28	8d. Describe	how injury	occurred	
Attendi death. ctor: A y the fu	cati	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	t h o			М		Yes 2 🗆					
or All	Certification:	4 ☐ Homicide determin	ned 28e. Place of buildin	of Injury - At ho g, etc. (Specify	me, tarm, st y)	reet, tactory	y, office		28		Street and wn, State)	i Number or	Rural Route Number,
pltal ours a eral i		29a. Certifier 1 ★ Certifying	Physiclan: To the I	hest of my kno	wledne dea	th occurred	l at the tir	no date a	nd place as	nd due to the	2 221122(2)	and manna	r on atatad
To the Hospital or Attendia within 24 hours after death. To the Funeral Director, a completely filled in by the fu	edical	(Check only 2 Medical E	xaminer: On the ba	sis of examina	tion and/or in	nvestigation	n, in my o	pinion, de	ath occurre	d at the time	, date and	place, and	due to the cause(s)
To the within To the complex c	Me	29b. Signature and title of certifier	2			290	c. Licens	e number			29d. Date	e signed (Me	onth, Day, Year)
\		1	5///	10			De	0430	95		ELLO	11000	5 2000
·nx\		30. Name and address of person w	no completed cause	of death (Item	23a) (Type,	Print)			, -		1601-	willy.	12007
18 sx		DANIEUE DOBER	MAN, MO	6565	- 11/	MAR	155	ST.	SWIF	207	BALTIE	MIPS.	MD 21204
Sta	te	31. Date filed (Month, Day, Year)	22. Re	egistrar's Sign	ture	Ked							
Registr	ar	30. Name and address of person w DANIE Ut DOBLE 31. Date filed (Month, Day, Year) FEB 0 6 20	109 Alex	in p.	Allen								
HMH 17 Rev 1/2	001												
					OHIO	GINAL							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

03382

3. Time of Death

11:55 P M

Reg. No 2009

200^{Year}

2. Date of Death
Month
Day
February 4,

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND, ITEM#5perFH, G892,6/19/09, WS
State of Maryland / Department of Health and Mental Hygiene 03383 Certificate of Death Reg. No.2 0 0 9 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** FEBRUARY 5, 2009 3:40 A M DIXON ALEXANDER **JAMES** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Victorian Estates Assisted Living Bel Air 237-26-8184 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 □ F Director June 30, 1916 North Carolina Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 Is merked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits other treumatic event, the Medical Examiner must be notified at Funeral Director 1⊠Yes 2□No Maryland Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 46 Raymond Avenue 21001 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 X No Be Completed by Specify. Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 Ammunition Technician U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John (unk) Dixon ပ Dora (nmn) Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Barbara Dixon / Wife 46 Raymond Avenue, Aberdeen, MD 21001 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages
Dispartment of
Important: If it
any Injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Jarrettsville Cem. 2-7-09 4 ☐ Donation 5 ☐ Other (Specify) Jarrettsville, MD 22. Name and Address of Facility
McComas Funeral Home, P.A. 21. Signature of Funeral Service Licensee Marles U min 1317 Cokesbury Rd., Abingdon, MD 21009 A air ins that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on each line. 23a. Part 1. Enter the disease, or composition shock, or heart failure. List only or Approximate Interval Between Onset and Death Immediate Cause (Final CIRPHOSIS CRYPTO GENIC **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any national cause in a chalcause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day P.O. 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, KIDNEY DISENSE 1 ☐ Yes 2 M No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗆 No 1 ☐Yes 2 ANO 1 Yes ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Assisted 1∐ Yes 2∭21Ño Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year)
FERSINARY 5, ZOO9

State

Registrar

31. Date filed (Month, Day, Year)

0 6 2009

arks

BRAICE MPZIOIX

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Certificate of Death

1 - For State Registrar

*	Physicia /Medic	al		atn 1 M
1	Examin	er		
	· · ·		Calvert Memorial Hospital Prince Frederick Calvert 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or F	oreian
	Funeral Director		5. Social Security Number $ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	o. o.g.,
	-		Usual Residence of Decedent	
	yland now		10a. State 10b. County 10c. City, Town or Location 10d. Inside City	Limits
	a-f st	혅	MD Anne Arundel Harwood ¹□Yes 2	X No
	or 28	ire	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
	th wil	a	1501-M Flanders Lane 20776 USA	
	72 hours after death with the Maryland natural", or Items 23a or 28a-f show ileal Examiner must be notified at	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.	
36	or lt	by Fu	1 □ Never Married 2 □ Married 1 1 ▼ 1 Yes 2 □ No	
8	hours ural'	q p	3 Wille	
7-	n 72 "nat	lete	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry	
12	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene 1 feath and Mental Hygiene 1 feath 23 a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the IM-dical Examiner must be notified at	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Carpet Installer Flooring	
9	Hygie Hygie other		17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)	
lan	ould be Mental larked o	To Be	Antonio Farnese Carmella Foleno	
2	2 should bend and Menis marked	-	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
Ž	1 and 2 Health a tem 27 is		John A. Farnese, son 1210 lynbrook Drive Huntingtown, MD 206	39
ē,	es 1 a of Hei		20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State	
E	Pages nent of H int: If ite		1 Burial 2 Micremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory, Inc. 02/05/09 Baltimore, MD	
Baltimore, Maryland 21215-0036	init and		21. Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of MD, Inc.	
m	permi Depar Impor any ir		Serve E Mar Mrs. 299 Frederick Road Baltimore, MD 21228	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between	en
	Physician		Immediate Cause (Final disease or condition resulting in death) a. A cute Renal Failure Onset and Dec	ath
	/Medical		Due to (or as a consequence of):	
	Examiner		Sequentially list conditions b. Acute Tubular Necrosis	
١	D ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	
	death certificate be executed e attending physician and d for use as the burial-transit	Examiner	trial initiated events C.	
Ö,	e exe		resulting in death) Last Due to (or as a consequence of):	
68760,	ate b hysic the b	Physician/Medical	d	
9 ×	death certifica attending pl	Me	IF FEMALE:	
Вох	ath c	ian/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf pregnancy 1	ar
		/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	
P.O	The law requires that the de ate has been signed by the a page 2 should be detached to		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of dea	th?
ds,	signe d be	l by	Newly Diagnosed Uncontrolled Diahetes 1 Yes 2 No 3 Probably 4 Duni	
Ö	w require been si should b	Completed		
3ec	has has ye 2 s	du	Tschaemic Colitis 24a. Was an autopsy findings available and prior to completion of cause death?	ailable se of
a			1 Yes 2 No 1 Yes 2 No	
Vital Records,	sician: certific rector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No	
ō	Phys r this ral di	. To	1 Inpatient 2 EH/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 LiOther (Specify)	
on	ding F. h. After funera	tion	27. Manner of Death 1	
Division	Atten deat sctor	fica	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office 28f. Location (Street and Number or Bural Boute Number	Τ,
Ö	afor after	Certification:	4 ☐ Homicide building, etc. (Specify) City or Town, State)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
	he He in 24 he Fi	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
	With To t	Σ	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	
			leyen. c. Jurona D 50653 2-4-2009	
1	1,		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GYAN. C. SURANA 5851 - Deale Churchton Road. Deale mp 20757	
_	0 NA		5851 - Deale Chunchton Road. Deale mp 2075)	
	Sta Registi		31. Date filed (Month, Day, Year) 33 Registrar's Signature 34. Carl	
	negisti	rai	ILD V 2003 MOREOVED M. Aprilla	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 03385 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Month 3. Time of Death FIGGS 3,2009 2:40 AM FEBRUARY

permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be retified at Baltimore, Maryland 21215-0036

Physician

Examin

Funeral Director

Physician /Medical

Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

ı I	ANNA		zivo etroot a	nd number)			4b. City, Town,	or Location of	f Death	~ ~	4	c. County	of Death)
	4a. Facility Name (If no	ot institution, g	jive street a		000	-	1 1	a second of	200				A / A	
	BON	SELL	URS		SPI		BAL	11/11		RE		/	VA	
	5. Social Security Num		. Sex 1 ☐ M 2 5		(In yrs. las		If Under 1 Year Months Days		24 Hrs. Min.	8. Date of Bi (Month, D	irth ay, Yea <i>i</i>	r)	9. Birth	nplace (State or Fo untry)
	212-20-6		1 L W 2	ع ا	33	Yrs.							MAI	RYLAND
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	Toa. State	ob. County	1-		,			~						10d. Inside City Li
	MARYLAND	NI	19		1	5917	TMOR							1 ¥Yes 2 □
7	10e. Street and Number					_	10f. Zip Code				10g. C	Citizen of W	Vhat Cou	intry?
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5 1	11. Marital Status		12. Was	s Decedent E	ver in U.S.	13.	Was Decedent of If Yes, specify Cul	Hispanic Orig	in? (Spec	cify Yes or N	0-			ican Indian,
2	1 Never Married	2 Married	d 1 🗆	ned Forces?]Yes 2 ∑ No	0				, rueno r	rican, etc.)		Blac	k, White,	, etc.
2	3 Widowed 4	☐ Divorced	Yea	es, Give ir or Dates:			1 ☐ Yes 2 ☑ No	Specity:				Specify.	B	LACK
3	(015	5. Decedent's	Education	t - 410		16a. Dece	dent's Usual Occu	pation			16b.	Kind of Bu	ısiness/Ir	ndustry
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3	17. Father's Name (Fin	rst, Middle, La:	st)					18. Mother	's Name	(First, Middle	e, Maide	n Surnam	ie)	
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1115	19a. Informant's Name	e/Relationshin	/Type Prir		T		ng Address (Stree							
	LINDA				ED) QO 74
- 7	20a. Method of Dispos			TUGHT			osition (Name of	WICIF	Da Da					own, State
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	4 ☐ Donation 5	Other (Spec	cify)		MT.	ZION	I CEMETI	ery o	0/07	12009	BAG	LTIM	WRE	MARYUR
	21. Signature of Fune	ral Service Lic	ensee	/. >	. 00 .	_2	2. Name and Addr	ess of Facility	04.21	I TR.	FU.	NER	AL.	HOME
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Registrar DHMH 17 Rev 1/2001

State

THOMAS

31. Date filed (Month, Day, Year) FEB 06 2009

BON

MARYLAND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No U Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician Anita Marie Fitzgerald 02 09 05 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Wicomic nice Birthplace (State or Foreign Country) If Under 1 Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Year 5. Social Security Number **Funeral** Days Min. 1 □ M 2 🔀 F 213 28 8185 77 Maryland Director 01/01/1932 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10b. County 10a State 28a-f show if from 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Modical Examinar must be nothered. 1 ☐ Yes 2 🔯 No Somerset Director Maryland Princess Anne 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 10453 Clarence Barnes Road 21853 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒ No 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) should be filed within 72 hours after and Mental Hygiene. 1 □Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 X Married 1 ☐Yes 2 X No Specify: 2 Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental William Henry Ozman Bertha Alice Dill 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) and 2 s 200 Willow Lane Glen Burnie, Maryland 21061 William Fitzgerald / Son Department of Healt Important: If item 2 any injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 ament of He 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 02/10/2009 Baltimore, Maryland Cedar Hill Cemetery 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 monuning 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician END 2 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of) been signed by the attending physician and should be detached for use as the burial-trar Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 🗆 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1∐Yes 2√ZMo 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 7 No 3 Probably 4 Unknown 1 □ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed this certificate 2 410 1∐Yes 2.521170 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE Hospital: 1 Yes 2 ₩e 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 1FT Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death 2 Accident filled in by the 6 □ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records, To the Hospital within 24 hours a To the Funeral D Hospital

Maryland 21215-0036

Baltimore.

State

Medical

29a, Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001 TAZ

32. Registrar's Signature

and manner stated

30. Name an ress of person who completed cause of death (Item 23a) (Type, Print)

Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** $31^{\text{Day}}, 2009^{\text{ea}}$ January 7:33 P M Saunders Foxx Shirley /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Clinton Southern Maryland Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Y)
June 10, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Months 1 □ M 2 🛛 F 1943 Washington, DC 65 Director <u>578-58-5513</u> Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State show , and Mental Hygiene. Is marked other than "natura", or items 23a or 28a-f shov raumatic event, the Modeal Evancinar must be rediffed at 1 ☐ Yes 2 TNo Director Caroline Bowling Green Virginia 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 19211 Wrightsville Road 22427 U.S.A. Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No 2 Specify. Specify: 3 X Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Background Investigator US Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental HI Important: If Item 27 is marked oth any Injury or other traumatic event Be Carrie Bell Myers Joseph Alphonso Saunders, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Son) 19211 Wrightsville Rd., Bowling Green, VA Melvin M. Foxx, Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Lawn Cemetery 2-7-09 4 ☐ Donation 5 ☐ Other (Specify) Woodford, VA 21. Signatur of Funeral Service Lice 22. Name and Address of Facility
C.W. Edwards Funeral Home 16476 Richmond Turnpike, Bowling Green, VA 22427 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 210 e /Medical Due to (or as a consequence of): Examiner 5 ٢ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4. ☐ Unknown us certificate has been sidirector, page 2 should l Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was autopsy performed Ves 2 No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certified completely filled in by the funeral direct r. p.

State Registrar

DHMH 17 Rev 1/2001

FEB 0 6 2009

Bol

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Check only one)

me

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

132 MD 32. Registrar's Signature

ORIGINAL

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

98

SouThern Ave

29d. Date signed (Month, Day, Year)

SI, DC2

1 - For State Registrar

			1 - State Registrar			Certificate of	Death		Re	g. No. 2	009	03388
П	Physici	an	1. Decedent's Name (First, Middle, La	,					Date of Death Month		Year	3. Time of Death
	/Medic		Joseph Charles Fie						ebruar	у Ś,	2009	11:21 A ^M
	Examir		4a. Facility Name (If not institution, giv			4b. City, Town,		of Death			nty of Death	
-			Stella Maris Hospi		//	Timor		24 Uro 1 o	D		altimo	
	Funeral Director		5. Social Security Number 6. S 214 26 0493 Usual Residence of Decedent	M 2□ F 7. Age 7	(In yrs. last birth Y	Months Days		Min. Ju	Date of Birth (Month, Day, ne 23,	Year) 1929	Cou	place (State or Foreign ntry) rland
	land ow		10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits
	Mary First	ţċ	Maryland Baltimor	re	Mic	ddle River					1	1 □Yes 2X No
	n the	Director	10e. Street and Number			10f. Zip Code			10	g. Citizen	of What Cou	ntry?
	h wit		1635 Bowley's Quar	ters Rd.		21:	220			USA		
36	i within 72 hours after death with the Maryland jaene. r than "natural", or items 23a or 28a-f show the Medical Evaniner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married	12. Was Decedent Ender Armed Forces? 1 X Yes 2 □ Note If Yes, Give 1 Year or Dates:		13. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2X No			y Yes or No- an, etc.)		Race - Ameri Black, White, ecify: Whi	etc.
21215-0036	hour tural		3 ☐ Widowed 4 ☐ Divorced 15. Decedent's E	,		Decedent's Usual Occ	unation		1		f Business/Ir	
15	in 72 "nat	Set	(Specify only highest gra	ade completed)	(Give kind of work don life. DO NOT use retir	e durina mos	st of working	10.7		more (*
712	within jiene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+		Pump Opera	tor				Depart	
b	othe ent,	BeC	17. Father's Name (First, Middle, Last)			18. Mothe	er's Name <i>(Fi</i>	irst, Middle, M	aiden Suri	name)	
/lar	should be nd Mental marked c	To E	Henry Joseph Fiedl	ler			Rose	Josep	hine Cl	harva	.t	
Maryland	. Pages 1 and 2 should by tment of Health and Ments tant: If Item 27 is marked jury or other traumatic e	ľ	19a. Informant's Name/Relationship (Type. Print)	19b.	Mailing Address (Stree	et and Numbe	er or Rural R	oute Number,	City or To	wn, State, Zi	p Code)
≥,	and sealth m 27		Lucy Fiedler (Wife)								yland 21220
ore	t of H		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of I	Disposition (Name of crematory or other pi	lace)	Date	I		on - City or To	
Ë	tmen tant: jury		4 ☐ Donation 5 ☐ Other (Special	(y)	Maryland	d Veterans					ville,	Maryland
Baltimore,	permit. Pages Department of Important: If It any Injury or once.		21. SignAture of Funeral Service Lice	urkounko		Bruzdzins 1407 Old	ress of Facilit Ki Fun Easter:	eral H n Aven	lome P. <i>i</i> lue Esse	A. ex, M	arylar	nd 21221
			23a. Par 1. Enter the lisease, or com shick, or heart failure. List only	plications that caused to	he death. Do no	ot enter the mode of d	ying, such as	s cardiac or re	espiratory arre	st,		Approximate Interval Between
- (Physician		Immediate Cause (Final disease or condition			IVE PULMON	IARY D	TSEASE				Onset and Death
	/Medical		resulting in death)		consequence of		mil D.	LUMIUU				
	Examiner	Ļ	Sequentially list conditions,	b								
	ted isit	Examiner	Sequentially list conditions, if any leading to himself to cause. Enter Underlying Cause (Disease or injury	Dun to (or as a	our suquence of)t						
	execu and al-trar	xan	that initiated events resulting in death) Last	c Due to (or as a	consequence of):						
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687	ifficate g phy as the	Medical		d								
Вох	eath certificate be executed attending physician and for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		3 ☐ Ectopic pregna	ncv			23d.	Date of deliv	
O.	the death by the atter	Physician,	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnant at 9 ☐ Unknown		5 ☐ Other (specify)					Month	Day Year
Ρ.	that the de led by the detached	Phy	9 Unknown		mot voquiting in	No confort in a second	-i i- D I		Ogo Did tob			the entre of death 2
Š	es ign be	by	Part II. Other significant conditions	contributing to death but	not resulting in	the underlying cause g	jiven ≀n Paπ i	١.				the cause of death?
0.0		eted							I X I 168	s 2 🗆 N		bably 4 Unknown
3ec	2 88 2	Completed							24a, Was an autopsy		prior to co	opsy findings available ompletion of cause of
Vital Records,		S							perform 1 ☐ Yes 2		death? 1 ☐ Yes	2 □No
Z:	Physician: this certific ral director,	a	25. Was case referred to medical examiner?	Hospital:			Ale e e e		heck only one		=	
of		2	1 ☐ Yes 2 🗶 No 27. Manner of Death	1 ☐ Inpatier 28a. Date of Injury		Datietit 3 1 DOA	4 L IN		5 Resider Describe hove			ty) HOSPICE
on	ding F th. After funera	흲	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day,	Year) In	ury W	ork? □Yes 2□		. Describe nov	v injury oc	curred	
Division	Il or Attending after death. I Director: After d in by the fune	ifica	3 ☐ Suicide 6 ☐ Could not b		y - At home, farr	n, street, factory, office			Location (Stre	eet and Nu	ımber or Rur	al Route Number,
ă	al or / s after il Dire	Certification:	4 ☐ Homicide determined	building, etc.	(Specify)				City or Town,	State)		
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	ledical (29a. Certifier 1 ☐ Certifying Pl (Check only 2 ☐ Medical Exal one) X Nurse Prac	nysician: To the best of miner: On the basis of	examination and	death occurred at the /or investigation, in my	time, date ar opinion, dea	ath occurred	due to the ca at the time, da	use(s) and te and pla	d manner as ce, and due t	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and litle of certifier			29c. Lice	nse number		29	d. Date siç	gn é d (Month,	Day, Year)
	7		1 AAAINO	CKNP		RIL	1979	2		215	12000	7
	0. 1		30. Name and address of person who	completed cause of de	ath (Item 23a) (1	ype, Print)	1112			10		1
11	0+1		JACKIE JONES, CR	NP 2300 D	ULANEY V	ALLEY RD.	TIMO	NIUM,M	D 21093	3		
	Sta		31. Date filed (Month, Day, Year)	32 Registra	's Signature	1						
Div	Regist		FEB 0 6 200	9 Charren	B. A	arked						
υHI	MH 17 Rev 1/2	1001										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TTEM#23e, perPHYS, G888, 2/10/09, WS State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death JÄNUARY 30 2009 Μ. FINE MARVIN 6:30 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE 11105 OLD CARRIAGE ROAD GLEN ARM If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days **X**□ M 2□ F 86 215-12-8848 MD 02/02/1922 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 □Yes 2 □ No BALTIMORE GLEN ARM 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21057 USA 11105 OLD CARRIAGE ROAD 12. Was Decedent Ever in U.S. Armed Forces?

Y Yes 2 No
fYes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 □Yes 2**√**□No Specify Specify: WHITE 3√ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **FURRIER** FUR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) FINE **JACOB** MARY GOLDBERG 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11105 OLD CARRIAGE ROAD RANDOLPH FINE / SON GLEN ARM, MD 21057 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State BALTIMORE HEBREW CEM. 02/02/2009 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signat e of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dementio Due to (or as a consequence of) Sequentially list conditions, if a year of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last NYUNIC Due to (or as a consequence of) Chronie 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) I Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 Ho 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 💢 Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Examiner certificate be executed burial-tran Box 68760, attending physician use Division of Vital Records, P.O. the ģ has To the Hosping.

within 24 hours after death.

To the Funeral Director: After this certificate

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Physician

/Medical

Examiner

Funeral

Director

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permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiens Important: If Item 27 is marked other the any injury or other traumatic event, 11 once.

Physician

Examiner

/Medical

Baltimore, Maryland 21215-0036

Physician/Medical Completed Be Certification: To Medical

J. MIRBANZA 31. Date filed (Month, Day, State Registrar

4 Thomicide

29a. Certifier

29b. Signature and title of certifier

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

505 US/EX INISHE

Year)

32. Registrar's Signature

			For State Registrar	State of I	Maryland	-	artment rtificate			ind Me		ene	009	03390	
Ī	Physic		Decedent's Name (First, Middle, La RACHEL LEE GORE	st)							Date of Death Month	Day	Year	3. Time of Death 12:15A M	
	/Medi Examir		4a. Facility Name (If not institution, giv				F	ORT		f Death		4c. C	ounty of Death		
	Funeral Director		234 90 2512	Sex 7. I□ M XX F	Age (In yrs. la	as <i>t birthday)</i> 54 Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	Min.	Date of Birth (Month, Day, EB. 10,		Coun	place (State or Foreign htry) VIRGINIA	
	e Maryland a-f show tifled at	ctor	Usual Residence of Decedent	GEORGES		Town or Lo		ON				10d. Inside City Lim XX Yes 2□			
	with that a or 28	Dire	10e. Street and Number 3015 HENSON BRII		CE		10f. Zip (Code 0744			10	•	en of What Cour	•	
980	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hyglene. I health and Mental Hyglene. I have 12 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at	by Funeral Director	11. Marital Status XXX Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 Tes Xi If Yes, Give Year or Date	ent Ever in U.S es? MNo			ent of His fy Cuba		gin? (Specif i, Puerto Rio	y Yes or No- can, etc.)	14	4. Race - Americ Black, White, Specify: BLAC	an Indian, etc.	
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	2 should be filed withir and Mental Hygiene. is marked other than aumatic event, the Me	Be	17. Father's Name (First, Middle, Last	1+		MEMBE	<u>ERSHIP</u>	COC	18. Mothe	r's Name (F	First, Middle, M		RIVATE furname)		
Maryland	should and Men s marke umatic	은	GLEN GORE 19a. Informant's Name/Relationship (Type. Print)		19b. Maili	ng Address	Street a		HEL JO er or Rural F		City or	Town, State, Zip	Code)	
	ges 1 and 2 t of Health a If item 27 is or other trai		TIA GORE-AMBROSI		20b. Pl	8604 lace of Dispo	BOTLE osition (Nam matory or other	e of	i	FOR'			ON, MD 2 ation - City or To		
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Bal	permit. Departr Importa any inju		21. Signature of Funeral Service Lice	DONALD		Y 43	308 SU	ITLA	AND RO	OAD :	SUITLAN	D, 1	ZLAND, 1 1D 20746)	
)	Physician /Medical Examiner		23a. Part1. Enter the disease, or conshock or eart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. MALIG Due to (or b. SPECI	NANT N as a consequ FIED I	EOPLAS Jence of): NTEST	SM, CE	CUM			FHOUT M		ION	Approximate Interval Between Onset and Death	
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and large 2 should be detached for use as the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	X OF HE	RNIA as a consequ										
O. Box 6	the death certific y the attending p ched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes ▼▼ No 9 □ Unknown		h 2 ☐ Fetal nt at time of de	death 3	⊒Ectopic pre ⊒ Other (spe			·		23	3d. Date of delive Month	ery Day Year	
Δ.	law requires that the de as been signed by the a 2 should be detached		Part II. Other significant conditions	contributing to deat	th but not resu	ılting in the u	inderlying ca	use give	en in Part I.		23e. Did tob			he cause of death?	
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Vital	Physician: The rather than this certificate har all director, page	Be	25. Was case referred to medical examiner?	Hospital:				Othe		of Death (Check only one				
or	ਦ ਦੁ ਲ	T0	1 ☐ Yes ※※ No 27. Manner of Death	28a. Date of	Injury	ER/Outpatier 28b. Time o		Bc. Injury	/ at		Reside d. Describe ho		Other (Specif	(y)	
Division or Vital Records,	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Certification:	XX Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not be 4 Homicide determined	n 28e. Place of	Day Year) injury - At ho , etc. (Specify	Injury me, farm, st	M reet, factory,		(? Yes 2 □ I		f. Location (Str City or Town	(Street and Number or Rural Route Number,			
Ω	To the Hospital c within 24 hours af To the Funeral D completely filled in	Medical Cer		death occurred at the time, date and place, and due to the d/or investigation, in my opinion, death occurred at the time,					e cause(s) and manner as stated.						
	To the Hwithin 24 To the Fu	Mec	29b. Signature and title of certifier	and mannel					number	_		29d. Date signed (Month, Day, Year) 02/04/09 [ARGO MD 20794]			
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State Registrar 31. Date filed (Month, Day, Year)
FEB 0 6 2009

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year OUISE 20090710 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death NA If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex Days 1 □ M 2 🗷 F 237-50-4079 Yrs 100 N. CARDLINA MAY 29, 1908 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No BALTIMORE MARYLAND 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21214 4802 HERRING RUN DRIVE U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐Yes 2X No Specify: If Yes, Give Year or Dates: Specify: BLACK 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ALSTON LUTHER DMONDS LULFI 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CARROLL (DAUGHTER) 3247 YOSEMITE AKE, BALTIMORE, MD 21215 OLIVIA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State KING MEMORIAL PARK DQ-OS-2001 BALTIMORE, MARYLAND 4 Donation 5 Other (Specify) 22. Name and Address of Facility
505EPH H. BROWN JR. FUNERAL 21. Signature of Funeral Service Licenses 2140 N. FULTON AYE, BALTIMORE, MD 21217 liamo 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final A se unknown disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Unsace of highly that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Physician /Medical Examiner the death certificate be

Physician

/Medical

Examiner

10a. State

Director

Funeral

ð

Completed

Be

2

Funeral

Director

marked other than "natural", or items 23a or 28a-f show imatic event, the "modeal Eventians", and be puilted as

permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygie Important: If item 27 is marked other th any injury or other traumatic event, the once.

within 72 hours after death with

Maryland 21215-0036

Baltimore,

Division of Vital Records, P.O.

N

Examine physician and s the burial-transit Physician/Medical attending pl ed by the a signed b þ Completed peen has filled in by the funeral director, Be Certification: To this ie Hospital or Attending P n 24 hours after death. ie Funeral Director: After t After 1

		Month Day Tear
	23e. Did tobacco us	se contribute to the cause of death?
_	1 ☐ Yes 2 ☐	No 3 Probably 4 LUnknown
_	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2-4No
Death (Check anly one)	
ng Hom	e 5 Residence 6	☐Other (Specify)
28	d. Describe how injury	occurred

				1 □Yes 2 No	1 ☐ Yes 2 1 No							
25. Was case referred to medical examiner? □ 1 Yes 2 □ No		26. Place of Death (Check only one)										
		Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)										
Z LI Accident	investigation		28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury of	occurred							
3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	d not be rmined	28e. Place of Injury - At home, farm, street, fac building, etc. (Specify)	28f. Location (Street and I City or Town, State)	Number or Rural Route Number,								
29a. Certifier 1 Certify	ing Phy	ysician: To the best of my knowledge, death occur	red at the time, date and place,	and due to the cause(s) a	nd manner as stated.							
(Check only 2 Medica	al Exam	niner: On the basis of examination and/or investiga	tion, in my opinion, death occuri	red at the time, date and p	lace, and due to the cause(s)							

29c. License number

D0018230

5	
	State

To the Hosp within 24 hor To the Fune completely fi

Medical

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

FEB 06

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FALATHLL

25.0

SHASH IDHARAN, 32. Registrar's Signature

DO018230 February 2/2009 Com a Sumaintan Hornital, MD2/239

DHMH 17 Rev 1/2001

Registrar

		4	For State Registrar	State of Maryland	•	artment of H Artificate of E			ene . №. 2009	9 03392		
Phy	ysicia	n	1. Decedent's Name (First, Middle, Last)	ry F. Gwinn			2. Date of Death Month January	th Day Year 3. Time of Death				
	ledica		4a. Facility Name (If not institution, give str	·		4b. City, Town, or	Location of Death	-	4c. County of Deal			
Exa	amine	er	4a. Facility Name (in Not institution, give sit			Linthic	77	_	Anne Arundel			
Fund	oral		5. Social Security Number 6. Sex	7. Age (In yrs. la.	st birthday)	If Under 1 Year	If Under 24 Hrs.	8 Date of Rirth	9 Bir	thplace (State or Foreign		
Direc			212 42 4490	^{M 2} © F 65	Yrs.	Months Days	Hours Min.	(Month, Day,) 11/08/1	943 Vi	Virginia		
D			Usual Residence of Decedent									
ırylar	10	_	10a. State 10b. County		Town or Lo	cation Cum Height				10d. Inside City Limits 1 ☐ Yes 2 🛣 No		
e Ma 8a-f	HE I	엃	Maryland Anne Ar	140	10g. Citizen of What Country?							
ith th	3	Directo	10e. Street and Number			10f. Zip Code	000	100		ountry?		
filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show	ust	ar a	300 Church Circle	10.1		090	posify Vos er No	U.S.A.	vican Indian			
er de	DBC	Funeral	11. Marital Status 1 Never Married 2 Married	 Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 	. 13.	Was Decedent of Hi f Yes, specify Cubar	n, Mexican, Puert	Rican, etc.)	Black, White			
rs aff	XX	by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □Yes 2X No	Specify:		Specify: White			
hou atura	빌		15. Decedent's Educa	tion			ent's Usual Occupation 16b. Kind of Business/Industry					
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at Hy othe	event, the Medical	Be (17. Father's Name (First, Middle, Last)	1 D 1				ne (First, Middle, Ma	•			
uld b Ment irked	tic e	2	Ca	arl Pauley			Mar	y McBride	!			
d 2 should be filed within the and Mental Hygiene.	traumatic		19a. Informant's Name/Relationship (Type						City or Town, State,			
ss 1 and 2 of Health item 27 i	Tr.		Vicky Gunther / Da			Gaither	Road S		, Maryland			
of H	r ot		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Re	\ 1 ce	ace of Dispo metery, crer	sition (Name of natory or other place	e)	Date 20	c. Location - City or	Town, State		
permit. Pages Department of Important: If it	uny		4 □ Donation 5 □ Other (Specify)	Mead		lge MemF)2/2009 E	Elkridge,	Maryland		
permit. Departr Importa	nce.		21. Signature of Funeral Service Licenses		22	2. Name and Addres	is of Facility Go	nce Funer	al Servic	e, P.A.		
icate be executed		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): SEVERE CHRONIC OBSTRUCTIVE LUNG Due to (or as a consequence of): DISEASE EMPHYSEMA Due to (or as a consequence of):									
ath certif attending	for use as the bur	Physician/Medical	d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		23d. Date of de Month	livery Day Year						
at the de	ched	iysi	1 □Yes 2 12/No 9 □ Unknown	9 ☐ Unknown								
juires that n signed b	pe q	ρ	Part II. Other significant conditions cont	ributing to death but not resul	ng to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of 1 Tres 2 No 3 Probably 4							
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ın: T ificat	irector, page 2 s		25. Was case referred to medical				26 Place of Dea	1 □Yes 2 ath (Check only one)		s 2 □No		
rslcia s cert	lirect	o Be	examiner?	ospital: 1 ☐ Inpatient 2 ☐ E	ER/Outpatie	nt 3 DOA Othe	NP:		ce 6 ☐ Other (Specify)			
ding Phys th. : After this	funeral c	tion: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time o Injury	f 28c. Injury Work	y at	28d. Describe how		outy)		
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To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica	completely filled in	Medical (29a. Certifier 1 Certifying Physi (Check only one) 1 Medical Examin	ician: To the best of my know er: On the basis of examinat and manner stated.	vledge, deal ion and/or ir	th occurred at the tir nvestigation, in my o	ne, date and place pinion, death occu	urred at the time, da	te and place, and du	e to the cause(s)		
	E	Σ	29b. Signature and We of certifier			29c. License			d. Date signed (Mon	th, Day, Year)		
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To within			Mucul	Mio. Phi	1 sici	an D4	2041	C	2/03/0	09 L MD 2122		

State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1 1 9 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Ellen H. Gordes 1:18 P M February 4, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. Aug. 22, 1936 5. Social Security Number 9. Birthplace (State or Foreign Country) Maryland 6. Sex 7. Age (In vrs. last birthdav) **Funeral** Months Days 1 ☐ M 2 ☑ F 219-26-5927 72 Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits artment of Health and Mental Hygiene, ortant: If Item 23a or 28a-f show ortant: If Item 27 is marked other than "natural"; or Items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Towson Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 911 Rappaix Court 21286 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No þ Specify. 3 Widowed 4 Divorced white Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Lead Research Medical Tech. Medicine Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be nent of Health and Mental Oscar Hessler Dorothy Kelly 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 911 Rappaix Court; Towson, MD 21286 Henry W. Gordes husband timore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 3 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any injury or once. Dulaney Valley Mem Gardens: 2/9/09 Timonium, MD 21. Signature of F neral Ser 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home Towson, MD 21204 23a. Part1. Enter the disease, or comshock, or heart failure. List only ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Immediate Cause (Final disease or condition resulting in death) HEMORRUAGE Physician HRS /Medical Examiner ANCYTOPENIA MONSHS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and as the burial-trar Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 menths? Month Dav Year 5 Other (specify) the 9☐Unknown 9 Unknow þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 🗌 Yes 3 Probably 4 □Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 patient Medical Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No after death filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide the Hospital within 24 hours a

To the Funeral [ortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, -Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Pnnt)

32. Registrar's Signature

COVIEW, MD.

0 6 2009

2

027730

6569 N. CHARLA ST. BATMORE, MD

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 0.130 2009 Hawkins <u>Aldine</u> Η. /Medical 4a, Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery

9. Birthplace (State or Foreign Country) Holy Cross Hospital
5. Social Security Number 6. Sex Silver Spring
If Under 1 Year F If Under 24 Hrs. 7. Age (In yrs. last birthday Date of Birth (Month, Day, Year) Funeral Hours Months Days Min. 1 □ M 2 T F Director 239-48-6741 87 11/20/1921 NC Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 Tx Yes 2 □ No Director DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 20019 4117 Massachusetts Avenue SE Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2√2No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes ŽŽNo Baltimore, Maryland 21215-0036 Specify: þ Specify: Black 3 ☐ Widowed 4 ☑ Divorced 'natural", Completed th and Mental Hygiene.
7 is marked other than "natur traumatic event, the Medical. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 6th grade Minister 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and 2 should be Carrie Annie Gatlin William Percy Horton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Paula Stevens Lassiter/daughter 4117 Massachusetts Avenue SE Washington DC 20019 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Pages 1 Department of H Important; If ite any Injury or otl once. 1 Surial 2 □ Cremation 3 □ Removal from State 2/11/09 | Brentwood MD 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 21. Signa are of Functial Service 22. Name and Address of Facility Marshall's Funeral Home 4217 9th St NW Washington DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) a. Pulmonary Embolism /Medical Due to (or as a consequence of) Examiner Chronic Obsructive Pulmonary Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and the little interest of the little in Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Deep Vein Thrombosis Division or Vital Records, P.O. Box 68760 resulting in death) Last Due to (or as a consequence of) Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 🛣 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2x No 3 ☐ Probably 4 ☐ Unknown Diabetes Completed 24a. Was an Were autopsy findings available prior to completion of cause of page 2 s autopsy performed' XXYes 2 □ No ial or Attending Physician: Tis after death.

I Director: After this certificate od in by the funeral director, pa Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2√ ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 🔯 Natural 5 ☐ Pending investigation 1 Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 ☐ Suicíde Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined completely filled in by 4 Homicide within 24 hours a To the Funeral I To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature D58962 2/4/2009 of person who completed cause of death (Item 23a) (Type, Print) Suite 103 Olney, MD 20832 Shashank Patel Georgia 6 2009 32. Registrar State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death rd Year Day 3rd Month **Physician** HORSHAW MARGARET 10:00 AM FEBRUARY /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore NONTHWEST GOSPITAL CENTER Randalstown If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 ☐ M 2 🔀 F Director 05/04/1921 Maryland 215-18-6152 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Funeral Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 U.S.A. 601 Brookwood Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 ☐ Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 ☐XNo Specify Specify: Black Completed by 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Day Care Provider 9 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Monroe Hill Mary Demby 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4708 Fdmondson Avenue, Baltimore, Maryland 21229
ce of Disposition (Name of Date 20c. Location - City or Town, State Lillian Makle / Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition ty Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/09/2009 Woodlawn, Maryland Woodlawn Cemetery 22 Name and Address of Facility The Derrick C. Jones F/H, P.A. 21. Signature of Funeral Service Licens 4611 Park Hgts. Ave., Baltimore, Maryland 21215 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SEPSIS Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed burial-transit cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋧ ART ERY DISEASE. 1 Yes 2 No 3 Probably 4 Unknown CORONARY page 2 should Completed 6 STEOMY ELITIS 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has autopsy performed? 1 □ Yes 2 □ No TRAG certificate URINARY completely filled in by the funeral director, Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📆 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death e Funeral Director; 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number
D 42723 29b. Signature and life of JUND-FEBRUARY 30. Name and address of person, who completed cause of death (Item 23a) (Type, Print) NORTHWEST AUYER CLOI OLD COV HOSPITAL OLD COURT 5401 31. Date filed (Month, Day, Year)
FEB 0 6 2009 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

			4	For State	State of Ma	arylar					Mental Hy	/giene				
			1. Decedent's Name (First, Middle, Last)				rtificate of Death			1 - 5 - 15	Reg. No. 2009 03396					
	Physic		D EDANGES AT DEDWA TITLE								2. Date of D Month	Day			3. Time of Death	
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	aryland show		10a	. State 10b. County		10c. Ci	ty, Town or Lo	cation	_					10d.	Inside City Limits	
	Ba-f s	Director	-	MD PRINCE GE	EORGES	Т	EMPLE 1								XXYes 2 □ No	
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21215-0036	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exeminer must be notified at	þ		1 □ Never Married 2 □ Married	Armed Forces? 1 ☐ Yes		1	fYes,spec □Yes			Specify Yes or Note to Rican, etc.)		Black, White	te, etc.		
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Maryland	2 sho and sme		19a	a. Informant's Name/Relationship (7	ype. Print)		19b. Mailin	g Address	(Street and Nu	mber or R	ural Route Numb	er, City o	or Town, State,	Zip Co	de)	
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Hill Frances 2/2/09 1358

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Hartlove, Carrol1 Jr. February 4,2009 8:30 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kingsville Baltimore 8407 Bradshaw Road 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 71 Maryland **Director** Usual Residence of Decedent 10b. County 10c. City. Town or Location 10a State 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It a Medical Examinatings burnating at Director Kingsville 1 □Yes 2 □XNo Md. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21087 USA 8407 Bradshaw Road Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? 1 Yes 2 No Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: چ ک Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Plumbing Plumber 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carroll Wilber Hartlove, Sr. Viola Malin 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8407 Bradshaw Rd. Kingsville, Md. 21087 Charlotte Hartlove/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith 2-7-09 Baltimore, Md. 22. Name and Address of Facility
Ruck Towson Funeral Home,
1050 York Rd. Towson, Md. 21. Signature of Fund of Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** END-5-AGE C 0, P 20 YRS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the death certificate be executed and burial-1 Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown Hospital or Attending Physician: The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed?

1 \(\text{Yes} \) 2 \(\text{No} \) certificate 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) this c 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturai 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Within 24 hours after death

To the Funeral Director:
completely filled in by the 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Description the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only one) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mD6363 Z 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kum 941 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 06 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Ebruary erou 5:34AN 151 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Bon Secous 9. Birthplace (State or Foreign ENTINGE If Under 1 Year If Under 24 Hrs. Hospital 5. Social Security Number 8. Date of Birth (Month, Day, Age (In vrs. last birthday) **Funeral** 1 M 2□ F Months Days Hours Min Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantient must be notified at any injury or other traumatic event, the Medical Evantient must be notified at any injury or other traumatic event, the Medical Evantient must be notified at any injury or other traumatic event. 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Funeral Director more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 N No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No If Yes, Give Y Year or Dates: Specify. Completed by Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ (Wite 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or R - Route Number, City or Town, State, Zip Code) 4 Mrs. Carolyn 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatore of Funeral Service Licenses wieras Ba 23a. Part.1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or es a consequence of): Approximate Interval Between Onset and Death Athenischerene cardio vasular diseas **Physician** /Medical Due to (or es a consequence of): Examiner End Stage
Due to (or as a consequence of): Seque, tially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last renal Examiner The law requires that the death certificate be executed To the Hospital or Attending Physician: The law requires that the death certificate be executi within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran hypuleroio Due to (or as a consequence of) P.O. Box 68760, diabere Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Jonknown 25tomyelite Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 1 ☐Yes 2 ☐No 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manne of Death 1 Natural 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

HOSPITAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bonsewur

Cort in

6

31. Date filed (Month, Day, Year)

DDD56240

Baltimore

2000 W. Baltimore St,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death February **Physician** 20Ŏ9ª Cecilia M. Ham 2. Рм 8:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice Timonium Baltimore If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Min 1 □ M 2 🕅 F 212-10-2521 08/03/1916 Pennsylvania 92 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Baltimore Nottingham 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 2 Flanders Court Apt. B 21236 U.S.A. Pages 1 and 2 should be filed within 72 hours after death anent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or items 23 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TX No Specify. Completed by Specify: 3 Nidowed 4 Divorced White 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Needleworker Textiles 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jan Wronka Marianna Slaba ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Cornelia H. Lingley - Daughter 8320 Old Dominion Drive McClean, VA 22102 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Important: If it any Injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Louden Park Cemetery 02/04/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, Maryland 21214 Unla Mene 23a. Part 1. Enter the of sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician DEMENTIA resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or jury Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 🗷 No 23d. Date of delivery 3 Ectopic pregnancy Month Ye ar Day 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Be Completed by 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐Yes 2X No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\mathbb{R} \) Other (Specify)\(\mathbb{HOSPICE} \) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: completely filled in by the f 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and marine as stated.

Nurse Practitioner 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 200 30. Name and add ess of person who completed cause of death (Item 23a) (Type, Print) CRNP JACKIE JONES, 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Moritin; Day, Year) 32. Registrar's Signature State 06 FFR Registrar

DHMH 17 Rev 1/2001

2009

FEBRUARY

CECILIA HAM

ORIGINAL

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend item 23c per doc g888 2-6-09 vt
State of Maryland / Department of Health and Mental Hygiene 2 0 0 9 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year AMES 200 04:24 AM ANUAR 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death BAYVIEW MEDICAL JOHNS HOPKIN N/A TIMOR 7. Age (In yrs. last birthday)
74 Yrs. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 4,1934 5. Social Security Number Birthplace (State or Foreign Months Hours Days 216-30-1989 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Dundalk Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 2818 Plainfield Road United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. 1- Yes 2 No If Yes, Give Year or Dates: 1956–62 1 Never Married 2 Married 1 □Yes 2 No Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 Years Pickler-Finishing Steel Mill 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James O. Hanlin Marine B. Sollars 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2010 Plainfield Road Dundalk, Maryland 21222 19a. Informant's Name/Relationship (Type. Print) James H. Hanlin (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Kaubaugh Cemetery 1/28/2009 Elk Garden, WV 4 Donation 5 ☐ Other (Specify) Funeral Service Licensee 21. Signat 22. Name and Address of Facility Puda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 VEDO 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart cause. List only one cause on each line. Approximate Interval Between Onset and Death I Hour Immediate Cause (Final disease or condition resulting in death) ARDIOPULMONARY Due to (or as a consequence of) SEPTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Sepsis Due to (or as a consequence of): IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed/ 1 Tes 2 W No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

> State Registrar

Physician

/Medical

Director

Completed by Funeral

Be

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Examiner

Physician/Medical

2

Completed

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Medical Certification: To

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the McCal Exercite 1, and be notified at once.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RES-000 Jan. 25, 2009

PhD 4940 EASTERN AVENUE BALTIMORE, MD 21224 R-ENOH M 31. Date filed (Month, Day, Year) FEB 0 6 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 0 9 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** nomas :56 PM 200 0 /Medical 4a. Facility Name (If not institution, give street and number 4b. City. Town, or Location of Death 4c. County of Death **Examiner** saltmore mor If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign
Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 X M 2 □ F Months Days Hours Min 16,1919 Pennsylvania Director 90 295-03-5989 January Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location show 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, Ire Modical Expanient must be notified at Director 1 ☐ Yes 2 No Perry Hall Balto Md 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 21128 IIS 9814 GunForge Road Funeral 12. Was Decedent Ever in U.S.
Armed Forces?

1 ☑ Yes 2 ☐ No Army 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 2 should be filed within 72 hours after or and Mental Hygiene. Is marked other than "natural", or iter 1 ∑Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Draftsman Engineering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Florence McDowell ည Thomas Hannon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health an Important: If item 27 is r any injury or other traur Spouse 9814 GunForge Rd. Perry Hall, Md. 21128 Elsie L. Hannon 20b. Place of Disposition (Name of cemetery, crematory or other place)
Druid Ridge 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-4-2009 Balto.Co. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** noxIC /Medical Due to (or as a consequence of): Examiner OU Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and burial-trar Due to (or y a consequence of) Box 68760. signed by the attending physician Physician/Medical the as use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 D Ectopic pregnancy jo in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.0. 1 ☐ Yes 2 ☐ No detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ þ 1 Yes 2 No 3 Probably 4 Unknown Completed been : 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an has autopsy performed? Yes 2 No this certificate 1 ☐ Yes To the Hospital or Attending Physician: 'within 24 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 은 2 ER/Outpatient 3 DOA After thi funeral c 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Director: d in by the f 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ause of death (Item 23a) (Type, Print) amountain 2. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Amend #1 per MD g888 2/6/09 TT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene.

			For State Of Maryland State Registrar	Cert	tificate of i			_{eg. No.} 2009	03402
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Carlton France		erl	95	2. Date of Deat Month	Day Year	3. Time of Death
	Examir		4a. Facility Name (If not institution, give street and number) Northwest Hospital Cuts		4b. City, Town, or Randal	Location of Death		4c. County of Dea	
	Funeral Director		5. Social Security Number 215−24−1783	st birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day, July 24	year) 9. Bin C ,1927 Balt	rthplace (State or Foreign ountry),Maryland
	and bw		Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Loca	ation		¥		10d. Inside City Limits
	Mary a-f sho	ctor	Maryland Baltimore	Baltim	ore				1 ☐ Yes 2√∑ No
	th with the 23a or 28	Funeral Director	10e. Street and Number 6809 Richardson Road		10f. Zip Code 21207		1,	og. Citizen of What C United Sta of Americ	tes
9800	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Maricel Evaring must be notified at once.	by	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 5 ☑ Yes 2 □ No If Yes, Give Year or Dates:		as Decedent of H Yes, specify Cuba □Yes 2⊡tNo	ispanic Origin? (Spe un, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Am Black, Whit Specify: Wh	e, etc.
Baltimore, Maryland 21215-0036	ithin 72 h ne. han "natu	Be Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give ki life. Di	O NOT use retired	durina most of workir	99	16b. Kind of Business Social Se	curity
d 21	filed w Hygie ther ti	S	12 17. Father's Name (First, Middle, Last)	Anal	yst	18. Mother's Name	(First, Middle, N	Administr	ation
'lan	uld be Aental rked o	To Be	Arthur T. Hoerl				ldie Ec	,	
lary	2 shou and N is mai		19a. Informant's Name/Relationship (Type. Print) John D. Hoerl/ son					City or Town, State,	
e) Le	1 and Health em 27 other to		20a Method of Disposition 20b Place	ce of Dienoei	tion (Name of	, D		e, Marylan 20c. Location - City or	
timo	it. Pages rtment of rtant: If it njury or c		MS Burial 2 ☐ Cremation 3 ☐ Removal from State Dulid 4 ☐ Donation 5 ☐ Other (Specify)	netery crema aney V morial	alley Gardens Gardens	e) Febru 5, 20	ary 09	Timonium,	Maryland
Ba	Depa Impo any li	7	21. Signature of Fineral Service Licensee	2	325 York	Road Ti	monium,	Maryland	
	Physician /Medical		23a. Part 1 / Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence)	Acid	the mode of dyin	g, such as cardiac o	r respiratory arre	est,	Approximate Interval Between Onset and Death Hours
	Examiner	ner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	ince of):					
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68760,	'tiricate be executed ig physician and as the burial-transit	Medical	d Acute Re	_Nal	Failure				
P.O. Box (Attending Frigstrant: The law requires that the death certificate be executed at death. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnanc 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of dea	leath 3 □ 1	Ectopic pregnancy Other (specify)	1		23d. Date of de Month	livery Day Year
rds, F	quires tna en signed l ufd be det		Part II. Other significant conditions contributing to death but not resulting Hyper Kalenia, Hyperglycem	-	lerlying cause give	en in Part I.		acco use contribute to s 2 □ No 3 □ P	o the cause of death?
al Records,	ang Fnysician: The law requir n. After this certificate has been s' funeral director, page 2 should I	Completed by					24a. Was ar autops perform 1 🗆 Yes 2	prior to death?	utopsy findings available completion of cause of
=	s certif	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☑ EF	P/Outpationt	2 DOA Othe	26. Place of Death		,	
n of	fer this	n. Ti		8b. Time of Injury	28c. Injury Work	at 2		nce 6 ☐ Other (Spe w injury occurred	ecity)
Division of Vital	Attending of death. ector: A sector: A by the fu	Certification: To	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home building, etc. (Specify)		M 1 🗆 '	res 2 □No	8f. Location (Str	reet and Number or Ri	ural Route Number,
	urs afte						City or Town		
	o the nospital of Attendant within 24 hours after death. To the Funeral Director: After completely filled in by the fur	Medical	29a. Certifier (Check only one) 1 ☑ Certifying Physician: To the best of my knowle cone one) 1 ☑ Certifying Physician: To the best of my knowle cone one one of the best of my knowle cone one one of the best of my knowle cone one of the best of my knowle cone on the best o	in and/or invo	etidation in my of	ninion dooth coourre	ed at the time de	to and place and due	to the equen(e)
	§ 2 ≰ 2	=	29b. Signature and title of certifier		29c. License	number 30 65 4 1	25	d. Date signed (Mont	h, Day, Year)
1	+1 vt	,	30. Name and address of person who completed cause of death (Item 23) Share A Katz wo 53	?3a) (Type, Pr	int)	15+ O.d	Rud	alls turn	MA 21133
İ	Sta Registr		31. Date filed (Month, Day, Year) September 1997 32. Begistrar's Signature FER 0 6 2009	e. Sa	aked	0/1 (50)	1-000	VI. 10 00 10	

amend #5 Per FH G888 2/27/09 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 **Physician** Feb. 6:00 P M LeRoy Brumbaugh Hartle, III 4, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WESTMINSTER CARROLL 1237 PINCH VALLEY RD. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours 64 MARYLAND Director 04/04/1944 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, It of the lessminer must be notified at 1 ☐ Yes 2 🖾 No Director MD CARROLL WESTMINSTER 10f Zin Code 10e. Street and Number 10g. Citizen of What Country? 21158 USA 1237 PINCH VALLEY RD. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 □Yes 2 Ϊ No Specify. Specify: WHITE ⋛ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CREATIVE DIRECTOR ADVERTISING 12 should be filed with and Mental Hygien 7 is marked other th 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Doris Franklin LeRoy Brumbaugh Hartle, Jr. ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 1 5 7 1 and 2 s Health an ELLEN W. HARTLE - WIFE 1237 PINCH VALLEY RD., WESTMINSTER, MD permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 2/6/2009 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State WINFIELD, MD 4 Donation 5 ☐ Other (Specify) SOUTH CARROLL CREMATORY Funeral Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A. 254 E. MAIN ST., WESTMIN

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. E. MAIN ST., WESTMINSTER, MD 21157 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) P.O. signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. \$ ficate has been siç r, page 2 should b 1 ☐ Yes 2 ☐ No 3[robably 4 🗍 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 ☐ Yes 2 ☐ No 2**/** 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 N Residence 6 Other (Specify) 1 ☐ Yes □No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death After t 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Hospital or Attending 1 Natural 2 ☐ Accident death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician 2 Medical Examiner: 29a. Certifier To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certific icense number 29d. Date signed (Month, Day, Year) 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 555 South Caster Street Washinster State 6 Registrar

DHMH 17 Rev 1/2001

			State of Maryland / Department of Health and Mental 1- State Registrer Certificate of Death		009	03404
	Physici /Medic		1. Decedent's Name (First, Middle, Last) 2. Date of Month February Tabelling Ho			3. Time of Death 2:58 A.M
1	Examin				unty of Death Egomery	
	Funeral Director			f Birth 1. 13, Year 91	9. Birthp China	ace (State or Foreign try)
	Aaryland I show	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Rockville		10	0d. Inside City Limits 1 Yes 2 No
	vith the h	Director	106. Street and Number 10f. Zip Code		of What Coun	•
	sms 23e	Funeral	199 Rollins Avenue, Apartment #604 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.		Race - Americ Black, White,	an Indian,
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1215-(within 72 hours after death with the Maryland ane. then 'natural', or items 23e or 28e-f show he Madical Exeminer must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) S+ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Key Punch Operator		of Business/Ind	·
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lary	2 should and Me Is mark sumatic	오	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route N	umber, City or To		
	s 1 and of Health lism 27 other tr		Dr. Horace K. Liang/ P.O.A. 6 Elmhurst Road, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cometary, crematory or other place) Date	-	on - City or To	
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Division	하셨는데	Certification:	3 Suicide 4 Homicide 3 Suicide 4 Homicide 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	on (Street and No r Town, State)	umber or Rura	Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical (the cause(s) and me, date and pla	d manner as sto ce, and due to	ated. the cause(s)
	To t To t	W	29b. Signature and title of certifier Gusha MD 29c. License number D0061096	02/0	gned (Month, 1	, ,
	12		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) USHA GOLL APALLI, 6121 MONTRUSEROAD, R	DUENII	LLE, M	1020852
	Sta Registr		FEBRUAR SERVICE AND A SERVICE			

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		For State			State	of Ma	arylan					nd M	lental Hy	•			01.0	2 [
		1 - State Registrar 1. Decedent's Nam	o (First Mids	llo (not)				(Sertific	ate of	Death		2. Date of De	Reg. No	2009		341	72
Physicia	in		, ,										Month	Da			me of Dea	
/Medic Examin		Desiree 4a. Facility Name (/							4b. 0	City, Town, o	or Location of	f Death	Janua		0, 2009 County of De		:57 A	M
€XdIIIII	C1	4405 Ren								,	Suitl				rince		05	
Funeral		5. Social Security N		6. Sex		7. Age	e (In yrs.	last birth	day) If U	nder 1 Year ths Days			8. Date of Bi	rth	9. B	rthplace (5		reign
Director		578-34-5		וו	M 2 3 F		81	Υ	rs.	Uno Dayo	l louis		11/22			HINGT	ON D.	c.
and t w		Usual Residence of 10a. State	10b. Count	y			10c. Cit	y, Town	or Location		-					10d. Ins	ide City Li	imits
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n the	Director	10e. Street and Nu		.ce G	eorge	.5	Su	тила		. Zip Code				10g. Cit	izen of What C	Country?		
th wit 23a o 1st be	g le	4405 Ren	a Road	l #2						20746-	_			Uni	ited St	ates		
r dea	Funeral	11. Marital Status			2. Was De Armed F	orces?		.S.	13. Was D If Yes,	ecedent of F specify Cub	lispanic Orig	in? (Sp., Puerto	ecify Yes or No Rican, etc.))-	14. Race - Am Black, Wh		an,	
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be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Be	17. Father's Name	(First, Middle	, Last)		_	-		_		18. Mother	r's Name	(First, Middle	, Maiden	Surname)			
Ment Ment arkec	၉	Edward									Hild		rthur					
12 sh h and r Is m rraum		19a. Informant's Na			,										or Town, State,	Zip Code)		
1 and Healt em 2		Neisa Wo 20a. Method of Disp		ghter			20b. F	Place of I	Disposition	(Name of			tland,		20746- ocation - City o	r Town St	ate	
ages ant of t: If it		1 ☐ Burial 2 4 ☐ Donation	■Cremation		emoval fron	n State	0	emetery	, crematory	or other pla	ce)	_	Peb 3		•			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fu			e		Ch	esar		Crema e and Addre	tory: ess of Facility		2009	Bel	tsville	, Mar	/Land	
Dep Imp any		1 Los	XX.	S									tion Se			20010		
7 E		23a. Part1. Enter t	he disease, o	or complicationly on	cations that	caused	the deat	h. Do no	ot enter the	mode of dyi	ng, such as	cardiac	or respiratory a	rrest,	aryland	Appro	ximate al Betweei	n
Physician		Immediate Cause ((Final	,	4	1/2	8.1			dise							and Deat	
/Medical		resulting in death)			Due to	o (or as a	a conseq	distribution of the second		CVIDE	UI U					-		
Examiner	_	Sequentially list co	nditions,	b.		· for on a												
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e dea the at ned fo	sici	in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	No		4⊟Preç 9⊟Unk		time of d	eath	5 ☐ Othe	r (specify) _					Month	Day	Year	
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signe d be	d b	v			Ü				,				1 🗆			robably		
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an: T tificat tor, pa	Be C	25. Was case refer	red to medica	al							26. Place	of Death	1□ Yes n (Check only o		1 LJYe	s 2□N	D	
lysici lis cer direc	P P	examiner? 1 □ Yes 2	No	Н	ospital: 1 [] Inpatier	nt 2 🗌	ER/Outp	atient 3	DOA Oth	or:				6 □Other (Sp	ecify)		
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eath.	atic	2 Accident	invest	igation					M	1 🗆	Yes 2□N	lo						
or Att	Certification:	3 ☐ Suicide 4 ☐ Homicide	deterr		28e. Plac buil	ce of Injuding, etc	ry - At ho . <i>(Specif</i>	me, farn y)	n, street, fa	ctory, office			28f. Location (City or To	Street an wn, State	d Number or F)	Rural Route	Number,	
purs a filled	ဦ	29a. Certifier	1 Certifyi	na Phys	ician: To th	ne hest o	of my kno	wledge	death occu	rred at the ti	me date and	d place	and due to the	031100/0	and manner	o stated		
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the bur	Medical	(Check only one)	2☐ Medica	l Examin	er: On the and ma	basis of nner sta	examina ted.	tion and	or investiga	ation, in my	opinion, deat	h occur	ed at the time,	date and	and manner a d place, and du	is stated. ie to the ca	use(s)	
To the within Fo the complex	ĕ.	29b. Signature and	title of certific	er n						29c. Licens					e signed (Mor	th, Day, Ye	ear)	
6		10	9	Key	00					466	066	5	•	Fol	Maris	3	2000	7
=		30. Name and addr	ess of persor	who cor	npleted cau	use of de	ath (Item	23a) (T	ype, Print)		^ .		7	100	0	40	1	
		Da. De	nna	Les	skust	w	- (120	0 B	isil (aurt	T~	Large	W	0 207	14		
Sta Registra	te ar	31. Date filed (Mon	FFR (6 200	32.	Hegistra	r's Signa	ture	lan.	. 1			O					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Jenkins Month Year **Physician** Scott 11:554 M 02 DI Z009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Future Care Nursing Home Baltimore Kandallstown Court If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1**X**M 2□ F Days Hours 212.20.4492 SC **Director** 09 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examinar must be notified at Baltimore Baltimore Funeral Director 1 ☐ Yes 2 X No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? or items 23a or Fox Meadow Road 21207 6700 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑No Specify: þ Specify: Black 3 Widowed 4 □ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Magnetic event, the Magnetic event, the Magnetic College (1-4or 5+) Elementary/Secondary (0-12) Stal Postal Service 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Julia Scott Jenkins Samuel မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) -Jenkins 6700 Fox Meadow Road Baltimore MD 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XBurial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 02/05/09 4 Donation 5 Dother (Specify) Baltimore, MD 22. Name and Address of Facility Vaughin C. Greene Fineral SVCQ 21. Signature of Funeral Service Licensee iberty Road Randall stown MD 2133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Due to (or as a consequence aftending physician a for use as the burial-Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the sempletely filled in by the funeral director, page 2 should be detached it ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🐧 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □Yes 2 ☑ No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of beath (Item 23a) (Type, Print)

The Charles Nimo 4 East Rolling Cross (Dads

Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

06

barked

4 East Rolling 32 Registrar's Signature

Catonsville NO 21228

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Month Day Year Waymon 10:06 AM 2009 01 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 3407 GWNN Dak If Under 1 Year If Under 24 Hrs. Baltimore Dayta Drive 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Months Days Hours Min. 1 M 2□ F 24-24-571 80 06/04/ Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits MD Baltimone GWYNN 1 ☐ Yes 2 No Oak 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3407 700 21207 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 1 □Yes 2 No Specify Specify: Back 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Bethlehem Steel 12thanade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Samuel Isle Payne 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Drive GWYNN Dak MD 21251 ita 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 Removal from State Owings Mills, MD Garrison Forest 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Vaudun C. Greene Funeral SVCS Vouch Road Randallstown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): miratus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tyes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 2 1NO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar physician and Division of Vital Records, P.O. Box 68760, hours after death.

Ineral Director: After this certificate has been signed by the attending physical birector of the funeral director, page 2 should be detached for use as the I

Physician /Medical

Physician

Examiner

Funeral

Director

28a-f show

Funeral Director

2

Be Completed

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Modical Evantine must be notified at any Injury or other traumatic event, the Modical Evantine must be notified at any once.

/Medical

Examine Be Completed by Physician/Medical Medical Certification: To

1 ☐ Yes 3 Suicide

27. Manner of Death 1 Natural 2 Accident

29a. Certifier

4 Homicide

6 ☐ Could not be determined

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature

State Registrar

within 24 hours a

To the Funeral C

completely filled

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM 5 PER FH G888 2-18-09 VT
State of Maryland / Department of Health and Mental Hygiene 03408 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Dorothy H. Johnson 3, /Medical February 2009 11:35 P4 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Nursing Center Baltimore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/15/1919 **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🛛 F Months Days Hours Director 89 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location r 28a-f show notified at show 10d. Inside City Limits Maryland Baltimore Timonium Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 'adical Examiner must be r 4 Ballycruy Court Unit #201 21093 U.S.A. Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc ☐Yes 2 X No f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 🔀 Divorced Specify: Year or Dates: White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) should be f nd Mental I C. Leo Hickey Rosa Weber 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health a Important; If Item 27 Is any injury or other trau Mrs. Colleen Morgan - Niece 4 Ballycruy Court Unit 201 Timonium, Maryland 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Most Holy Redeemer Cem. 02/09/09 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature / Juneral Service bicensee 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part1. Enter the disease, or complications that caused the de th. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical r as a consequence of): Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or, burial-transit Exami certificate be executed and Box 68760, Due to (or as a consequence of): physician Physician/Medical the attending | | for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery The law requires that the death 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year signed by the a d be detached f 5 ☐ Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records, 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 → nknown Completed peen 24a. Was an autopsy performed? 1□ Yes 2☑No 24b. Were autopsy findings available prior to completion of cause of has page 2 certificate death? 1 ☐ Yes SALVO Physician; 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 KNo Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To this funeral (28a. Date of Injury (Month, Day Year) 27. Magner of Death
Natural
Accident 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred Division To the Hospital or Attending 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur М 1 🗌 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only

State Registrar

F

31. Date filed (Month, Day, Year)

Loch

5601

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item, 23a) (Type, Print)

acen

32 Règistrar's Signature

12/Vd

29c. License number D 30 6 6

29d. Date signed (Month, Day, Year)

Februa

			1 - State of Maryland / De State of Maryland / De	partment of Health and Pertificate of Death	Mental Hygie	ne No.2009	03409
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Agnes Marie Johnson			Day Year 2009	3. Time of Death 10:00A M
-	Examir		4a. Facility Name (If not institution, give street and number) 954 W. Franklin Street	4b. City, Town, or Location of Dea Baltimore	th	4c. County of Death	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	Months Days Hours Min		ar) Coun	*/
	aryland show	'n	Usual Residence of Decedent 10a. State				0d. Inside City Limits 1X Yes 2 □ No
	ith the M or 28a-f	Directo	Maryland N/A Baltir 10e. Street and Number	10f. Zip Code	10g.	Citizen of What Coun	
	be filed within 72 hours after death with the Maryland ntal Hygiene. Ed other than "natural", or items 23a or 28a-f show event, the Modeal Evanine must be notified at	Funeral	954 W. Franklin Street 11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married	21223 3. Was Decedent of Hispanic Origin? (if Yes, specify Cuban, Mexican, Pue	Specify Yes or No- to Rican, etc.)	USA 14. Race - America Black, White, e	
-0036	hours aft	by	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 22 No Specify:	16b	Specify: Blac	
21215	d within 72 giene. er than "ne	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	ive kind of work done during most of wo e. DO NOT use retired) cher's Aide	Ba		City Publi
/land	2 should be filed and Mental Hygi is marked other aumatic event, II	To Be (12th grade 17. Father's Name (First, Middle, Last) Paul Hopewell	18. Mother's Na Cecil	me (First, Middle, Maid Lia	den Surname)	
Mary	es 1 and 2 should b of Health and Ment f Item 27 is marked r other traumatic e			ailing Address (Street and Number or F			
altimore, Maryland 21215-0036			157 Buriot 2 Cromation 2 Demoval from State Cemetery, C	idge Cemetery	709 Pil	kesville,	Md
Balt	permit. Pag Department Important: I any Injury o once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Ch 5240 Reisterstö	atman-Hai	rris Fune	eralHome
Sha.	Physician /Medical	4	23a. Part 1 Enter the disease, or complications that caused the death. Do not effock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):				Approximate Interval Between Onset and Death
	Examiner ind	Examiner	Sequentially list conditions, fary, Leading to in modals cause. Enter Underlying Cause (Disease or injury that initiated events				
8760,	ate be executed hysician and he burial-transit	dical Ex	resulting in death) Last Due to (or as a consequence of): d.				
O. Box 6	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	hysician/Mec		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deliver	y Day Year
ds, P.	w requires that the do	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to the	e cause of death?
r i	The ate h	Completed	RENAL CARCINOMA		24a. Was an autopsy performed	24b. Were autop prior to com	sy findings available ipletion of cause of
Vita	iysician: The lav ils certificate has director, page 2	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 inpatient 2 ER/Outpa	Other:	ath (Check only one)		
n of	ing Phy After this uneral d	on: To	1 ☐ Yes 2♣C No 1 ☐ Inpatient 2 ☐ ER/Outpa 27. Manner of Death 1 ☐ Natural 5 ☐ Pending (Month, Day, Year) 28b. Time (Month, Day, Year)	e of 28c. Injury at Work?	dome 5 Residence 28d. Describe how in)
DIVISION	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certifica completely filled in by the funeral director, to	Certification: To	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural ate)	Route Number,
	he Hospit in 24 hour he Funera pletely fille	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, do and manner stated.	eath occurred at the time, date and place investigation, in my opinion, death occ	e, and due to the cause urred at the time, date a	e(s) and manner as sta and place, and due to	ated. the cause(s)
	with com	Σ	29b. Signature and title of certifier WARRA T- SM TH W	29c. License number	29d. I	Date signed (Month, D	ay, Year) 2009
	HUT		30. Name and address of person who completed cause of death (Item 23a) (Typ. ZD00 W. BACTMBEF	FT Batt 40	717	223	
	Sta Registra		31. Date filed (Month, Day, Year) FEB 0 6 2009 32 Registrar's Signature	arke			

Amend 20b, per FH g888 2/11/09 TT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 031.10

546				1 - For State Registrar			ı ıvıaryıa		•	cate of	Death	Mental H		1e N201	9	03410
0	н	Physici	an	Decedent's Nam	e (First, Middle,	Last)						2. Date of E Month		Day	Year	3. Time of Death
		/Media	al	Leand 4a. Facility Name (I		zabeth Jo			46	Cit. Town	or Location of Dea	Febru			009	05:40 M
U	1	Examin	er									tn		4c. County		
		Funeral		5. Social Security N	Jra Memo	rial Hos	7. Age (In yrs	s. last birth	day) If I	Jnder 1 Year		8. Date of E	lirth	Harfo		place (State or Foreign
		Director		217-16-46	597	1 ☐ M 2 🂢 F	8	6 Yr	s. Mo	nths Days	Hours Min			922		yland
2/5/69		pu k		Usual Residence of	Decedent 10b. County		100.0	City, Town	or Locatio	2						10d. Inside City Limits
2	-	the Marylan 28a-f ehow	ក					,							1	1√2 Yes 2 No
2	•		Director	Maryland 10e. Street and Nu	Harfor	.a	Ha	avre		CACE M. Zip Code			10g. (Citizen of V	Vhat Cour	**
		3a or		415 Sc	outh Mar	ket St.				210	78			SA		
		deat	Funerai	11. Marital Status		12. Was Dec	edent Ever in	U.S.	13. Was I		lispanic Origin? (5 an, Mexican, Puer	Specify Yes or N		14. Race	e - Americ	can Indian,
1	5-0036	within 72 hours after ene. then "natural", or ite he Madical Exertira	by Fu	1 🗆 Never Marr 3 🗆 Widowed	ied 2□ Marrie 4 🔀 Divorced		2≱∑No ve			es 30 No		to riidan, oto.,		Specify		ite
0	200	72 ho	ted	(Spec	15. Decedent's	Education grade completed)		16a. E	ecedent's	Usual Occup	pation during most of wo	urkin a	16b.	Kind of Bu		
9	21	ithin on the	Completed	Elementary/Seco		College (1-4or 5+)	- 7	ife. DO N	OT use retired	d)	"Ally				
<u></u>	121	be filed within ital Hygiene. Id other then 'event, the Me	ပို	17 Fother's Name	(First Middle L	201		Cool	k		40 34-45-4-31-	15: 14:				cation
1	Maryland		Be	17. Father's Name	H. Moul						18. Mother's Na				Θ)	
Q	2	should the and Ment is marked	ဥ	19a. Informant's N				19b. N	Mailing Ad	dress (Street	and Number or R	(unk) I			State Zir	Code)
_						ro / Dau	ahter	555		Dr.		osit, N		3200		
1	Je,	of Health item 27 other tr		20a. Method of Dis	position		20b.	Place of D	Disposition	(Name of y or other place	ce) 102/	11/2009	20c.	Location -	City or To	own, State
5	Ē	Pages nent of ant: If it any or o		1 M Burial 2 4 □Donation	☐Cremation 3 5 ☐Other (Spe	3 □Removal from ecify)		-		J.M. Ce	1	mown	Ab	inado	n. M	arvland
~	Baltimore,	permit. Pages 1 end Depertment of Health Important: If item 27 any Injury or other tr once.		21. Signature of Fu	ineral Service Li	censee	Ω_{i}		22 Nau MCC	ne and Addre	ess of Facility Funeral F	Home, P.	Α.		-80	
		40244		23a. Part1. Ente(t	Da 000000 010	amplications that) Mu	TO DO DO	-131	7 Coke	esbury Ro	oad, Abi	nad	on, M	aryla	and 21009 Approximate
				shock, or hea	Halaure. List of	niy one cause on e	each line.	2010	//		1	c or respiratory	arrest,			Interval Between Onset and Death
	1	Physician /Medical		disease or condition resulting in death)	on .	a	/			MONI	4-					
	н	Examiner				Due to	(or as a conse	equence or):							
		_	ner	Sequentially list contains. Enter Under Cause (Disease or	enditions,	b. Due to	(or as a conse	quarios of	je.							
		ocuted nd transi	Examiner	that initiated events	5	c										
	68760,	ificate be executed g physicien and as the burial-transit	E	resulting in death)	Lasi	Due to	(or as a conse	equence of):							
	87	physi the b	edical		· ·	d										
				IF FEMALE: 23b. Was deceden	t prognant	23c. If yes, ou	tcome of pregr	nancy						23d Dat	e of delive	200
	Box	death e etter d for u	by Physician/N	in the past 12	months?	4 ☐ Pregr	ointh 2 Fell nant at time of			pic pregnancy er (s <i>pecify</i>)	у			Moi		Day Year
0	0	t the de by the tached	hys	9 ☐ Unknown		9□ Unkn	own									
0	S, F	w requires that been signed I should be det	by P	Part II. Other signif	ficant condition	s contributing to d	eath but not re	sulting in t	he underh	ing cause giv	ven in Part I.	23e. Dio	tobacc	o use contr	ibute to th	he cause of death?
5	ord	equir sen si ould i	ted									1 [] Yes	2□No	3 Prob	pably 4 Unknown
0	Record	4 2 5	Completed									24a. We	opsy	р	rior to co	ppsy findings available mpletion of cause of
												per 1 ☐ Yes	formed?	No 1	leath?	2KNO
F	Vita	sician: Th certificete rector, pag	Be	25. Was case refer examiner?		Hospital: A	,			Oth	100	ath Check only	7. 10.			
0	ō	Phys r this sral di	1. To	1 Yes 27. Manner of Deat	_	- 1		ER/Outp 28b. Tir		_ DOA	4 🗀 Nursing i	Home 5 ☐ Re 28d. Describe				(4
S	on	Attending Physician: r death. sctor: After this certific by the funeral director.	tion	1 Natural 2 Accident	5 Pending investiga		of Injury th, Day Year)	Inj	ury N	28c. Injur Wor	rk? Yes 2 ∐No			,,		
	Division	Attend er death rector: , by the f	Certification:	3 Suicide	6 ☐ Could no determin	Ad 286. Place	of Injury - At I	home, farn	n, street, f	actory, office		28f. Location City or T	(Street	and Number	er or Rura	al Route Number,
10	Ö	urs efte rat Dir iled in														
17		To the Hospital or Attent within 24 hours efter death To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one)	2 Medical E	Physician: To the xaminer: On the b	best of my kr asis of examir ner stated.	nowledge, on and/	death occ or investig	ation, in my o	opinion, death occ	e, and due to th urred at the time	e cause e, date a	(s) and ma and place, a	nner as s	tated. the cause(s)
	7	To Tro	2	29b. Signature and	title of centiler	Who he				29c. Licens	se number DGBAA	3.	29d. [Date signed	10	Oay Year)
		3 4		30. Name and add	ress of person w	The Completed care	se of death (Ite	em 23a) (T	ype, Print	Sila	len Aug	1411		MA	210	076
		Sta Registr		31. Date filed (Mon	oth, Day, Year)	32. F	Registrar's Sign	hat re	arke		7	1	1	1		
					AN A WEA	4.4										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1	For State OF IV	•	epartment of H Certificate of L				009	03411
	Physicia	ın.	1. Decedent's Name (First, Middle, Last)				2. Date of Deat Month	Day_	Žear 2009	3. Time of Death 2:15 AM
	/Medic	al :	Gloria Ann Kidd	-1	4h City Town or	Location of Death	Februar	-	2009	Z:13 F4w
	Examin	er	4a. Facility Name (If not institution, give street and numbe Manor Care Nursing Home	,	Roseda				ltimore	
**	Funeral		5. Social Security Number 6. Sex 7. A	ge (In yrs. last birtho	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, 01/02/1	Year)	9. Birthpla	ace (State or Foreign Carolina
	Director		215-40-2956 1□ M 2 x F Usual Residence of Decedent	67 Yrs	5.		01/02/1	942	NOT	.II CalUllia
	land ow	-	10a. State 10b. County	10c. City, Town o	r Location				10	d. Inside City Limits
	a-f sh	ctor	MD Anne Arundel	Pasade	ena					1 ☐ Yes 2 🙀 No
	or 28	Director	10e. Street and Number	-	10f. Zip Code		1	•	of What Count	ry?
	sath w		2958 Beaver Brook Court	t Ever in U.S	21122		ecify Yes or No-		Race - America	an Indian,
_	fter de ritem iirer	Funeral	Armed Forces 1 □ Never Married 2 □ Married 1 □ Yes 2 □		13. Was Decedent of H If Yes, specify Cuba		Rican, etc.)	E	Black, White, e	tc.
<u>₹</u>	72 hours after death with the Marylan "natural", or items 23a or 28a-f show idical Examilior must be rollified at	d by	3 ☐ Widowed 4 🙀 Divorced If Yes, Give Year or Dates	:	1 □Yes 2 □xxNo	Specify:				
<u>ب</u>	"natu	letec	15. Decedent's Education (Specify only highest grade completed)	(9	ecedent's Usual Occup Give kind of work done of ife. DO NOT use retired	ation during most of work B	ing	16b. Kind o	of Business/Ind	ustry
717	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, it a ffydles Exanticer must be redified at	Completed	Elementary/Secondary (0-12) College (1-4o	(5+) A	ccountant			Acc	ounting	9
פַ	e filed al Hyg other vent,	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name		Maiden Suri	name)	
<u>Xa</u>		70	Ernest Littlejohn			Alma P				0.40
Mar	S 8 .00 E		19a. Informant's Name/Relationship (Type. Print)		Mailing Address <i>(Street</i> 530 N. Poir					
ъ, _			Eddie Kidd/Son 20a. Method of Disposition		isposition (Name of crematory or other place				on - City or To	
<u></u>	Pages nent of int; If it ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Connation 5 ☐ Other (Specify)		Gifts Regist	ry 02/	05/2009	Hanov	er, Mai	ryland
Baltimore, Maryland 21215-0036	permit. Pages 1 an Department of Hea Important: If item 2 any injury or other once.		21. Signature of Funeral Solvice Licensee		22. Name and Addre	ss of Facility A	natomy	itts	Regist	ry MD 21076
10	20 E # 9		23a. Part 1. Enter the disease, or complications that cause	and the plants. Do no			·		mover,	MD 21076
			23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each immediate Cause (Final	line		what c	or respiratory arr	031,		Approximate Interval Between Onset and Death
	Physician / /Medical		disease or condition a.	as a consequence of)		MANIE			-	
	Examiner		Sequentially list conditions, b.							
	ted sit	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	as a consequence of)	:					
	ifficate be executed g physician and as the burial-transit	Examiner	that initiated events c	as a consequence of)	4 *					
68760	nte be nysicia ne buri	edical	d							
_			IF FEMALE:				320			
Box	leath certific attending p I for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	ne of pregnancy 2 Fetal death t at time of death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	ey .		23d	. Date of delive Month	Day Year
P.0.	ires that the de signed by the a be detached t	hysid	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown							
_	ss that gned b	by P	Part II. Other significant conditions contributing to death	but not resulting in t	he underlying cause giv	en in Part I.				e cause of death?
ord	w require s been si should b	ted	-							ably 4 Unknown
Division of Vital Records,	has by	Completed					24a. Was a autop perfor		prior to cor death?	psy findings available npletion of cause of
ā	in; Th ificate or, pag		25. Was case referred to medical			26. Place of Dea		2 No No	1 □ Yes	2 40
\equiv	ysicla is cert directe	o Be	examiner?	atient 2 ER/Outp	patient 3 DOA Oth	000	ome 5 ☐ Resid		Other (Specif	y)
o u	ding Physician: The In. After this certificate ha funeral director, page	on: T	27. Manne of Death 28a. Date of Month,		ury Wor	Ŕ?	28d. Describe h	ow injury o	ccurred	
sio	ttendi death. tor: A the fu	icati	2 Accident investigation	Injury - At home farm		Yes 2□No	28f Location (S	Street and N	lumber or Rura	l Route Number,
<u>></u>	I or Atteni after death Director: d in by the	Certification: To	4 ☐ Homicide determined building,	etc. (Specify)	n, street, factory, office		City or Tow	vn, State)		
	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use.		29a. Certifier (Check only) 1 Certifying Physician: To the beautiful Medical Examiner: On the basis	est of my knowledge, s of examination and	death occurred at the t	ime, date and place	e, and due to the	cause(s) ar	nd manner as s ace, and due to	stated. the cause(s)
	To the H within 24 To the F complete	Medical	one) and manner		29c, Licen				igned (Month,	
	5 × 6 0		29b. Signature and title of certifier		DT	777		21	2/09	
,			30. Name and address of person who completed cause of	of death (Item 23a),(T	Type, Print) Wham M	(. /.	1 0	A A	10 2 1 -	7/.
	W		Narardu Bharan 8		Whom V	rooms /	NOG.	M	1) 6 12	234.
1	Sta Regist	ate rar	31. Date filed (Month, Day, Year) 32. Reg	istrar's Signature	arkel					
			Box No. 2nd N. S. S. A. 4 4 5 5 7 5 14 17 17 17 17 17 17 17 17 17 17 17 17 17	1 1 1 1 1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieneo 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Richard Krause Month Year /Medical bran 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 5. Social Security Number 6. If Under 24 Hrs. Westical Centes 8. Date of Birth (Month, Day, Year) 01/01/1924 If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days 1 X M 2 □ F Hours 85 217-16-8096 Baltimore, Usual Residence of Decedent 10a. State 10c, City, Town or Location 10d. Inside City Limits MD Baltimore Director Baltimore 1 ☐ Yes 2 X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 605 Fuselage Avenue 21221 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1XIYes 2 □ No WWII IYes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married <u>≽</u> 1 ☐ Yes 2 █️No Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Swift Butcher 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ernest L. Krause Myrtle Clarke 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 605 Fuselage Avenue, Baltimore, MD 21221 Mary Frances Krause/ Wife 20b. Place of Disposition (Name of cemetery crematory or other place)

Evans Fineral Chape 1 02/10/09 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Forest Hill, MD 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 21. Signature, of Funeral Service, Licensee th. Enter it is disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heaf, failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause Final dr se or condition resulting in death) Solvent 12 60US Due to for as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter throughing Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? autopsy performe 1 □ Yes 2 No 2X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes No. N Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 2 Accident investigation М 1 ☐ Yes 2 No ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier

or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Division of Vital Records, P.O. Box 68760, attending pl detached certificate director, filled in by the funeral After To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely

Funeral

Director

28a-f show

?7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the "Modical Experience in a lat the notified at

and Mental Hygiene.

Department of Health a Important: If item 27 is any Injury or other trains

Physician

Examiner

/Medical

within 72 hours after

Pages 1 and 2 should

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

(Check only

29b. Signature and title of certifier

Ku, mo 31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940 Easten

and manner stated.

29d. Date signed (Month. Day, Year)

State of Maryland / Department of Health and Mental Hygiene 03413 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Year **Ellynne** Lillian King 7:20 ам February 5, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2001 Cherry Road Edgewood Harford If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 142-32-8685 1 □ M 2 🗶 F Months Days Hours Min. 67 **Director** NJ 04/30/1941 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f sho MD Ceci1 North Director East 1XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 Pinder Avenue 21901 USA items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, 72 hours after 1 ∐Yes 2 XI If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No Baltimore, Maryland 21215-0036 White 'natural', or 1 □Yes 2 No ģ Specify: Specify. 3 Widowed WDivorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manager Retail is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental William Cuthbertson Lillian Fowler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Keith King / Son item 27 i 2001 Cherry Road, Edgewood, MD 21040 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important; if ite
any Injury or oth Date 20c. Location - City or Town, State 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State Ardent Crematory 2/6/2009 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21203 Milistrall who 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** End Stage Chronic Obstructive Pulmonary Disease /Medical Due to (or as a consequence of) Examiner Tracheostomy Collar weeks Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence ot). law requires that the death certificate be executed Hypertension wiht Left Ventricular Hypertrophy burial-trai Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical Cardiovascular Accident wiht Hemiparesis weeks IF FEMALE yes, outcome of pregnancy
Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mon Month 4 ☐ Pregnant at time of death 9 ☐ Unknown Day Year 5 Other (specify) P.0. signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ Gastrostomy Tube, Morbid Obesity, Diabetes, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Be Completed Coronary Artery Disease, Dysphagia, Spinal Stenosis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate performed Gastroesophageal Reflux Disease, Depression 1 □ Yes 2**X** No 2 🗆 No 1 ☐ Yes Physician: director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Son!S 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 1X Natural 5 Pending Iniury 24 hours after death. 2 Accident investigation 1 ☐ Yes 2 ☐ No completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ça 29a. Certifier (Check only one) within 2 To the I the 29b. Signature and title of of rtifier 29c. License number 29d. Date signed (Month, Day, Year) D 54749 February 5, 2009 30. Name and address of person who completed cause of death (Mom 23a) (Type, Print) Allen Reilly, MD 801 Toll House Avenue, Frederick, MD 31. Date filed (Month, Day, Year). 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month February **Physician** Frank Lengal 200^{ye ar} /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Center Towson If Under 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In vrs. last birthday Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 □X M 2 □ F Pennsylvania 218-36-3975 71 January 12,1938 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, I've Madical Experiment mat be rediffed at once. 10a. State 10b. County 10c. City, Town or Location Funeral Director Harford Belair Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 100 G. Royaloak Drive 21015 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 (X Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 ☐ Never Married 2 X Married Saltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🛣 No Specify: δ 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 years Route Salesman Coca Cola Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles Lengal Catherine Mary Krupinski ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank C. Lengal 1922 Eastfield Road, Dundalk, Maryland son 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State February 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart of Jesus Cem. 9, 2009 Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 23a. Part 1. Enter the disease, of complications that caused the death on one enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 0 holic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3

Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 □ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

11:18 AM

9. Birthplace (State or Foreign

21222

Day

Year

Approximate Interval Between Onset and Death

10d. Inside City Limits 1 ☐ Yes 2 🛣 No

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records,

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) NUS 014 Certification: To 28d. Describe how injury occurred within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifier (Check only one)

Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

A death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JUSIS ON NOCHAT N. Charles ST CHALUBS MO 6701 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

Arthony Laricei In. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2009 03415 State of Maryland / Department of Health and Mental Hygiene 9-01026 INK UNK Certificate of Death 1- For State 3 Time of Death 2. Date of Death Registrar Month Day February 4, 2009 0239 hrs Decedent's Name (First, Middle,Last) Physician/ akicci Medjeal Examiner c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County Parkville** Joppa Road at Pershing Avenue If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Country) Deltmore 7. Age (In yrs. last birthday) if Under 1 Year Foreign 5. Social Security Number Min Hours Months Davs **Funeral** Director 10d. Inside City Limits Usual Residence of Decedent 10c. City, Town or Location Yes 2 No 10b. County 10a State 10g. Citizen of What Country? 28a-f show the Maryland 10f. Zip Code Director 10e. Street and Numbe or items 23a or 28a-must be notified at 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Funeral 11. Marital Status Armed Forces? 1 Never Married Married Yes Yes 2 No specify "natural", or If Yes Give Year Divorced 16b. Kind of Business/Industry 4 16a. Decedent's Usual Occupation (Give kind of work done If item 27 is marked other than "natural", or tranmatic event, the Medical Examiner à 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) rumore, MD 21215-0036
It. Pages I and 2 should be filed within 72 hor inent of Health and Mental II. Elementary/Secondary (0-12) 18 Mother's Name (First, Middle, Maiden Surname other 17. Father's Name (First, Middle, Last) marked Be (Street and Number or Rulal Route Number, City or Town, 19b. Mailing Address Relationship (Type, Print 19a. Informant's Nam 20c. Location Date 20b. Place of Disposition (Name of cemetery Method of Dispositio crematory or other place) Removal from State Baltimore, Cremation 3 2 Important: I -Adricuille permit. Page Department Other Specify 21. Signatore of Funeral Service Licensee Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and Physician Death failure. List only one cause on each line 'edical a. Multiple Injuries Immediate Cause (Final disease ∡miner Due to (or as a consequence of) or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and The law requires that the death certificate be executed 28f, per ME ,g889 3/25/09 TT X AMENDED 4b, Physician/Medical UNPENDED physician the burial -23d. Date of delivery 23c. If yes, outcome of pregnancy Year Day Box 68760. IF FEMALE Month 3 Ectopic pregnancy 23b. Was decedent pregnant in the past 12 months? Fetal death Live birth detached for use as Pregnant at time of death Other (Specify, 5 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 ✔ No 3 Probably 4 0.0 ò 24b. Were autopsy findings available 24a Was an Completed prior to completion of cause of Records, autopsy peen death? performed? 2 No 1 V Yes Yes 2 certificate has 26.Place of Death (Check only one) 25. Was case referred to medical Residence 6 V Other: Scene the Hospital or Attending Physician: Nursing Home 5 Division of Vital Be Hospital: 1 ER/Outpatient 3 examiner? Inpatient 28d. Describe how injury occurred 28c. Injury at Work this 1 Yes 28b. Time of Injury Occupant of a vehicle involved in collision 28a. Date of Injury (Month, Day Year) Feb 4, 2009 27. Manner of Death After 0230 hrs Yes 2 V No Certification: Natural Pending 28f. Location (Street and Number or Rural Route Number, City 24 hours after death. Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. Investigation or Town, State)
Joppa Road and Pershing Avenue, Parkville 2 🗸 Accident Could not be 3 Suicide (Specify) Major Road / Highway Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Homicide 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier 1 29d. Date signed (Month, Day, Year) and manner stated 29c. License number 29b. Signature and title of certifier February 4, 2009 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Patricia Aronica-Pollak MD 32 Registrar's Signatu 31. Date filed (Month, Day, Year) State Registra

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 03416 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 24° 200°9° February 3:15 а.м Gusmano Leanza Grazia /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Mt. Rainier 4100 30th Street | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | June 14, 5. Social Security Number 9. Birthplace (State or Foreign Country)
Italy 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □ KF 87 220-53-3095 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Marical Examinational Department once. Director MD Mt. Rainier 1 □Yes 2 No Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20712 4100 30th Street Italy Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ģ 1 ☐ Yes 2 X No Specify: Specify: White 3 ➡Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 8 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Maria (maiden not available) Vincenzo Gusmano 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4100 30th St. Mt. Rainier, Maryland 20712 Gabriel Leanza (son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Feb. 7, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory Beltsville, MD. 4 Donation 5 Dother (Specify) 2009 21. Signature of Furneyal Service Licensee 22. Name and Address of Facility Rapp Funeral & Cremation Service M00982 933 Gist Ave. Silver Spring, Maryland 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** We disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physiclan: The law requires that the death certificate be executed ending physician and use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical signed by the attending the detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 Yes 2 No 3 Probably 4 Unknown Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 □Yes 2 ☑No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Certification: To 1 Yes 2 No Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation the Funeral Director: Aff 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. vithin 2 29b. Signature,and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) senor Pd NW Wash 3800 fonth, Day, 06 32 Registrar's Signature 31. Date filed (Month, State

Registrar

			State of Maryland / D	k Indelible Ink. Ensure Department of Health are Certificate of Death	nd Mental Hygie	ne.2009 0341
Physicia /Medic Examin	al	Educard R 4a. Facility Name (If not institution, give st Sinai Hospital	treet and number) OF BACDMO		FEBRUARY Death	Day Year 17:58 PM 4c. County of Death
Funeral Director		5. Social Security Number 6. Sex 320-36-687 19 Usual Residence of Decedent 10a. State 10b. County	M 2□F 7. Age (In yrs. last birl	Yrs. Months Days Hours	Min. 8. Date of Birth	9. Birthplace (State or Foreign Country) VA
036 ours after death with the Marylar ral', or items 23a or 28a-1 show Examinant must be notified at	Funeral Director	MD NA 10e. Street and Number 4323 Fair-	Ball fax Rd.	Limore 101. Zip Code 21214	10g.	1 ØYes 2 □ No Citizen of What Country? USA
15-0036 72 hours after dea "natural", or items	by	1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F	? (Specify Yes or No- Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
	e Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)	ation 16a. College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired) Shipper 18. Mother's	r working	SECTION Survey
, Maryland 212: and 2 should be filed within seath and Mental Hyginds n 27 is marked other than her traumatic event, tra. M.	To Be	Gilmon Lewis 19a. Informant's Name/Relationship (Type Luliet Lewis) Wife 4:		on Brook	KS
Iltim nit. Pa ertmen ertmen ortant: injury		20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	moval from State 6 reen	Disposition (Name of y, crematory or other place) Went Cremeds of 22. Name and Address of Fallity	Date 2000 2/7/09 Bay	Location - City or Town, State A HIMAR MAD
Physician		23a. Part1. Enter the dilease, or complice shock, or heart valure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the death. Do no eause on each line.	8728 Libert not enter the mode of dying, such as call		Approximate Interval Between Onset and Death 22 days
/Medical tabe executed Examiner vsicien and table burial-transit	ical Examiner		Due to (or as a consequence of Due to (or as a consequence of	phocyTic us	nkemia	7 YEARS
Records, P.O. Box 68760, The law requires that the death certificate be executed to has been signed by the attending physicien and hage 2 should be detached for use as the burial-transit.	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
cords, P.		Part II. Other significant conditions control HYPERTENSION		the underlying cause given in Part I.		to use contribute to the cause of death? 2 No 3 Probably 4 Unknown
	Be Completed by	ANEMIA 25. Was case referred to medical examiner?	ELL ITMS	26. Place of	24a. Was an autopsy performed 1 Yes 2 2	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No
Division of Vita if or Attending Physician: after death. I Director: After this certification by the funeral director.	Certification: To	1 Yes 2 No Ho 27. Manner of Death 1 Matural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, tarr	ime ot 28c. Injury at jury Mork? M 1 ☐ Yes 2 ☐ No	ng Home 5 Residence 28d. Describe how in	and Number or Rural Route Number.
Hospi 24 hou Funer etely fil	edical	29a. Certifier 1 Certifying Physic	building, etc. (Specify)	death occurred at the time, date and plur investigation, in my opinion, death o	City or Town, Sta	(c) and magnet as stated
To the within 2 Complete	2	29b. Signature and title of certifier 30. Name and dress it person no com	pleted cause of death (Item 23a) (1	29c. License number RES ~ OOE Type, Print)	ि हिं	Date signed (Month, Day, Year) 3RUARY 2, 2009
Stat Registra	ar	MANTNAN, M. 31. Date filed (Month, Day, Year) FER 0 6 200	32. Rysistrar's Signature (Aparles Aparles	HOSPITAL	of ISALTIMORE

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Ye a **Physician** 9:03 PM FEBRUARY 03 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner Baltimore BALTIMORE AGNES HOSPITHL Date of Birth (Month, Day. If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Months Days Hours Min Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h. Count 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-1 show ary or other traumatic event, the Myclical Examinational benefited at 1 ☐ Yes 2 No Baltimore MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number SA 2120 by Funeral . Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify. Blac 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Building Mainterad stodian 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be min 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type. Print) Baltimore, ND 21267 vomas 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other pla Date 20c. Location - City or Town, State Department of Important: If it any injury or conce. 1 ☐ Burial 2 ☐ Cremation 3 Removal from State Baltimore, MD 2-9-09 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Vaughne Greene funeral siva 21. Signature of Funeral Service Licenses Randallstown, MD 21/33 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** DAYS PNEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ursease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed LAND CHARCES Division of Vital Records, P.O. Box 68760人 attending physician and for use as the burial-tran Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) cate has been signed by the a page 2 should be detached to 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ANOXIC ENCEPHALOPATHY SECONDARY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an TO SECON DARY HTSTORY OBSTRUCTION autopsy performed? Yes 2 No PRIOR 1 ☐ Yes 2 ☐ No LARYNGECTONY 1 ☐ Yes FOR Hospital or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ nous after death.

neral Director: After this
filled in by the funeral di After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

within 24 hounded the second to the second t

29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

BALTIMORE MD 21229

AVE

CATON

State

POLA 31. Date filed (Month, Day, Year) 6

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900 5 32. legistrar's Signatur racks

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year LEWis OAN SCAR 11:45 M M 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death CITY HOMEWOOD D GENESIS BALTIMORE If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 18 2 T F 69 219-36-1310 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Baltimore MI 1 ☐Yes 2 ☐ No 10g. Citizen of What Country? 10e. Street and Number 3043 Mathews Street U,S. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify. Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Charles Express river 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lewis, Sr. rene Braxton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3043 Mathews St. Bultinure MD 21218

ce of Dissosition (Name of Date 20c. Location - City or Town, State Kearneu Emma 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Parial 2 ☐ Cremation 3 ☐ Removal from State 1/22. Nam and Address of Facility Vaughn C. Greene Funeral Services 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 4905 York Ad Baltimore 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. WD SISIS Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Incommia Weeks Due to (or as a consequence of): Brench e sprie Carcinoma diffusby YOURS Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? mediast invin 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 1□ Yes 2 ANO

Physician /Medical **Examiner**

Physician

/Medical

Examiner

10a, State

Funeral

Director

r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at

Ith and Mental Hygiene. 27 is marked other than " r traumatic event, the Me

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othwany injury or other traumatic event.

Funeral Director

Completed by

Be

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Saltimore,

Box 68760.

P.O.

Records,

Division or Vital

physician and s the burial-trans attending p. for use as ed by the a detached f signed t cate has t certificate director, this funeral After

death certificate be executed Vo the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funera

State Registrar

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. adenocarcinosa Completed Ve menta ASCUD 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Medical Certification: 5 Pending investigation 1 Watural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

1) 31295

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21206

DHMH 17 Rev 1/2001

31. Date filed (Month, Day,

Klerky

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mo

₱32. Registrar's Signature

ORIGINAL

5701 Kenwood Ave

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Marylar					Mental Hy	giene)		
			Registrar 1. Decedent's Name (First, Middle, Las	net)	Ce	rtificat	e of L)eath	2. Date of De	Reg. No.	2009	1.03	420
	Physici		JOSEPH	LENTZ					Month Februar	D ==		4.1	5PM
1	/Medio Examin		4a. Facility Name (If not institution, give		·			Location of Death	_		County of Deat		
-	Lamin		HARBOR HO	OSPITAL				IMORE	5		N/A		
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs.	last birthday) Yrs.	If Under Months		If Under 24 Hrs. Hours Min.	8. Date of Bi	ay, Year)	Co	hplace (State	or Foreign
	Director		218 03 7293 1 1 Usual Residence of Decedent	94	170.				109/06/	1914	Ma	ryland	
	yland how		10a. State 10b. County		ty, Town or Lo	cation						10d. Inside (
	8a-fs	Director	Maryland N/A	A	Baltim								s 2□No
	with th		10e. Street and Number			10f. Zip		226		-	izen of What Co U.S.A.	untry?	
	ns 23	Funeral	1409 Elmtree St	12. Was Decedent Ever in U	.S. 13.	Was Dece		226 spanic Origin? (S _I n, Mexican, Puerto	pecify Yes or No		14. Race - Ame		
و	or items	Fur	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1		lfYes,spe 1 □Yes		n, Mexican, Puerto Specify:	o Rican, etc.)		Black, White		
93	ural",	d by	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:		dent's Usua				10h V	ind of Business/	hite	
15	in 72 n "nat	plete	15. Decedent's Ed (Specify only highest gra	cation (de completed) College (1-4or 5+)	(Give	kind of wo DO NOT us	rk done d se retired)	luring most of world)	king			ŕ	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Medical Examinar must be notified at	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Oro	dnance	e Mar	ı		Nava	al Ordna	ance La	ıb.
D	_ 0 2	Be	17. Father's Name (First, Middle, Last)	Charles Lentz				18. Mother's Nam	_{le (First, Middle} Lzabeth		,		
ryla	d Mental d marked of matic eve	스	19a. Informant's Name/Relationship		10h Maili	na Address	(Street a	Li L] and Number or Ru				Zin Coda)	_
Ma	nd 2 state and 2 s		Joseph Lentz Jr.	**		Glenr				-	le, Mary		21228
Jre,	es 1 a of Hei		20a. Method of Disposition	20b. I	Place of Dispo cemetery, crei	osition (Nar	me of other place	9)	Date	20c. Lo	ocation - City or	Town, State	
altimore,	Pagiment tant: h		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		ly Cro				09/2009	Ba1	timore,	Maryl	and
Ball	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any Injury or other traumatic evone.		21. Signature of Funeral Service Licen		11						Servic		
			23a, Part 1, Enter the disease, or comp	plications that caused the deal				nie Hight g, such as cardiac			ore, Mar	Approxima	ate
	Physician		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	STE	NOS	15					Interval Be Onset and	De <i>a</i> th
	/Medical		disease or condition resulting in death)	Due to (or as a consec		.,,						0101010	COIV
	Examiner	er	Sequentially list conditions,	b									
	uted I nsit	mine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence or):								
o,	exection and and rial-tra	Examin	that initiated events resulting in death) Last	Due to (or as a consec	quence of):								
68760,	icate be executed physician and the burial-transit	dical	•	, d									
39 x	ding p		IF FEMALE:	23c. If yes, outcome of pregn	ancy								
Вох	eath certific attending p	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of	al death 3	☐ Ectopic p☐ Other (sp		′			23d. Date of del Month	Day	Year
P.O.	t the d by the ached	Physician/M	1 □ Yes 2 □ No 9 □ Unknown	9 Unknown									_
S, F	es tha igned be det	by P	Part II. Other significant conditions of		sulting in the u	nderlying c	ause give	en in Part I.			use contribute to		/
Records,	requir	eted	HYPERTENSIC) 1 🗸							□ No 3 □ Pi		
Rec	has by	Completed	DEMENTIA						24a. Was auto perfe		24b. Were au prior to death?	topsy finding completion of	s available cause of
ta	an: Th tifficate or, pag	e Co	25. Was case referred to medical					26. Place of Dea	1 □ Yes	21/21No		2 🗆 No	
of Vital	ystcta is cer direct	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Impatient 2] ER/Outpatie	nt 3 DC	OA Othe	ar.			6 □Other (Spe	cify)	
0 0	ng Ph viter th uneral	on: 1	27. Manner of Death ↑ Natural 5 Pending	28a. Date of Injury (Month, Day, Year)	28b. Time o Injury	of 2	28c. Injury Work		28d. Describe	how injur	y occurred		
Sio	ttendi death. tor: A	icati	2 Accident investigation 3 Suicide 6 Could not be		omo form at	M factor		Yes 2 □No	29f Loggian	(Ctra at an	nd Number or Ru	um I Planta Alia	embor.
Division	after after Direction by	Certification:	4 ☐ Homicide determined	building, etc. (Speci	ify)	eet, lactory	y, onice		City or To			rrai Houte ivu	rriber,
١V	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	sal C		nysician: To the best of my knoniner: On the basis of examin									(e)
b	the H hin 24 the Fu	Medical	one)	and manner stated.	adon and/of if		c. License		at the time				(5)
	i		29b. Signature and title of certifier	heemshee	(a win			RES-0	00	Fol	te signed (Mont	1 (0.3)	2009
	0		30. Name and address of person who				*			1 ~ 7			
			SHEENU SHEELA 3	od S. MANOVI	ER 51.	, BA	LTIA	NORE, 2	.1225				
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	4.0							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend items 23a,b per doc g888 2-12-09 vt
State of Maryland / Department of Health and Mental Hygiene 2
Amend Item 29d per dr., g888, 02/06/09dhb
Certificate of Death
Reg. No. 1 - For State Registrar Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month January **Physician** 8:30 AM CONTHARD WILLAM 31 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | October 3,1919 KESWICK Burnover 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ▼ M 2 □ F 89 Yrs 167-18-9598 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show ns 23a or 28a-f shov must be notified at 1 X Yes 2 No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 4 Chancery Square 21218 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) is marked other than Attorney 6 Lega1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Henry Lenhard Mollie Cassandra Deaver 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 i Jane L. Lenhard/Wife 4 Chancery Square Baltimore, MD 21218 20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State 2 XC ematio permit. Pages Department of Important: If Its any Lyary or o 1 ☐ Bunaj 3 Removal from State Feb. 4 Donat 5 ☐ Other (Specify) 2009 Glen Burnie, MD 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Road Timonium, MD 21093 21. Sign flu Inc. Lowell M. Lemmon 23a. Parl1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final **Physician** recurrent pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner oro-pharyngeal dysphagia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dud to (or as a consequence of): Examine The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the bunal-trar Due to (or as a consequence of) $\mathcal{J}\mathcal{V}_{\mathcal{A}}$ Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9☐Unknown 9 ☐ Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ malnestrata 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No certificate 1∐ Yes the Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 2010 1 Yes ဥ this 27. Manny of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death.

neral Director: /
filled in by the fi 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide To the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) February 2, 2009 VI Stabelle Tac D13657 theeren HD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 141 MACGREGOR , YOOW- 40 K STREET, BALTITARE, ON 21211 D BRABELLE 31. Date filed (Month, Day, Year) 32. Registraris Signature State Registrar 6 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death - Physician Month William Miller February 2009 6:05 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7417 Chesapeake Avenue Edgemere Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Hours | Min. | January 5, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**X** M 2□ F 219-22-2175 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int: If item 27 is marked other than "natural", or items 23a or 28a-f show ary or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2X No Director Maryland Baltimore Edgemere 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code 7417 Chesapeake Avenue 21219 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. 1X Yes 2 No If Yes, Give Year or Dates: 1 Never Married Married 1 ☐ Yes 2 ☐ No Specify: White Specify ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Deck Hand Tug Boat 6 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter H. Miller Edna Hollingsworth ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7417 Chesapeake Avenue, Edgemere, Maryland Dorothy Miller wife 21219 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State February 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If i any Injury or Bayview Crematory 9, 2009 4 Donation 5 Dother (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. o not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final enera Physician disease or condition resulting in death) /Medical consequence of): Examiner Sequentially list conomons, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examine The law requires that the death certificate be executed altheres ig physician and as the burial-tran Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Wiknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 TYes 2 No 1∐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 Yes 2 No ို 1 | Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □Other (Specify) this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No after death 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ò 4 Homicide within 24 hours a 29a. Certifier 🗤 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar ASHIR

31. Date filed (Month, Day,

Year)

FEB 0 6 2009

3altimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

DRIVE

09-00943 Sharon Moore

Sharon Moore	1- For State Registrar	ate of Maryland	Department Certificate		d Mental H		g. No. 201	19 0312
Physician/	1. Decedent's Name (First, Midd		ise	Moore	741	2. Date of Death	1	3. Time of Death
Medical Examiner	Sharon 4a. Facility Name (if not institution		ise	Moore	Location of Death	Month February 1	, 2009 4c. County of De	2357 hrs
	3700 Greenspring Av	-		Baltimore				
Funeral Director	5. Social Security Number		e (In yrs. last birthday)	If Under 1 Yea Months Day			For	Birthplace (State or eign
Birector	216-04-0206 Usual Residence of Decedent	1 M 2 X F	39	Yrs.		03 11	L 69	Country) MD
w any	10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits
Aaryland Aaryland 1 at once.	MD N	IA	Bal	timore		145	g. Citizen of What Co	1 X Yes 2 No
he Mar or 28; iffed at		wing Aug A	n+ 006		1211			•
r death with the Maryland or items 23a or 28a-f sho must be notified at once. Funeral Director	3700 Greensp	12. Was Decedent	Ever in U.S. 13.	Was Decedent of His	spanic Origin? (Sp			erican Indian, Black,
er death	Never Married 2 M Widowed 4 Div		X No	If Yes, specify Cubar		Rican, etc.)	White, etc	
ours aft ntural" amine d by	15. Decedent's Education (Spe	or Dates:	pleted) 16a. Deced	ient's Usual Occupat	tion (Give kind of v		Specify: 16b. Kind of Busines	Black s/Industry
16 n 72 ho na 72 ho ical Ex	Elementary/Secondary (0-12)	, ,	i+) during	most of working life		red)	Marsha mi	
215-0036 be filed within 72 hours after death with the Maryland nital Hy & me had out or than "natural", or items 23a or 28a-f shout, the Medical Examiner mus be notified at once Be Completed by Funeral Director	12th grade 17. Father's Name (First, Middle,	Last)		Usher	18.Mother's Name	(First, Middle, M	Movie T	neater
ID 21215-0036 should be filed within 72 hours after and Mental Hygine. 7 is morked other than "natural" natice, cent, the Medical Examine To Be Completed by	Christopher				Elsie 1	Mosley		
dhou hou is n is n it is n	19a. Informant's Name/Relations Betty Anders		19b. Mai 9 1 3	ing Address (Street 5 Belair	et and Number or F	Rural Route Numb B alti n	ber, City or Town, Stanore, Md	ite, Zip Code) 21236
Baltimore, MI permit Pages I and 2 s Department of Health a Important: If item 27 injury or other travam.	20a. Method of Disposition 1 X Burial 2 Cremation	n 3 Removal from Sta	te crematory or		- 1 '	Date	20c. Location - City	or Town, State
Baltimore, ermit. Pages I an Department of He Important: If ite injury or other tr	4 Donation 5 Other S	pecify:	King Me	morial H		6/09	Woodlaw	n, Md
	Signature of Funeral Service	. Frugnit	<u> 14</u>		ash Ave		imore, M	d 21215
Physician /Medical	23a art I. Enter the disease, or failure. List only one cause	on each line.	the death. Do not ente arrhythmia		such as cardiac of	r respiratory arre	st, shock, or heart	Approximate Interval Between Onset and Death
xaminer	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conse		1				Death
-a	Sequentially list conditions, if any, leading to immediate	b	quence of):					
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0, e be exe ysician a burial -	XUNPENDED		a,PII,27,p	erME, g88	9 3/23/0	9 TT		
). Box 68760, the death certificate be executed to the attending physician and ched for use as the burial - tri Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth		Fetal death 3	Ectopic pregna	ncy	23d. Date of deliv	ery Day Year
OX 6876 eath certificate attending phy for use as the sician/M	1 Yes 2 No 9 Uni	(nown I		Other (Specify)				,
O. B at the de by the lached i	Part II. Other significant condit		but not resulting in th	e underlying cause g	iven in Part I.	23e. Did tob	pacco use contribute	to the cause of death?
Records, P.O. The law requires that the freath of the seen signed by age 2 should be detacl Completed by F.	Diabetes mel	litus				1 Yes	2 No 3 P	robably 4 V Unknown
ords, aw requir nas been s 2 should						24a. Was a autops perform	y prior to	autopsy findings available o completion of cause of
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of Vital Records, ag Physician: The law requirement of the this certificate has been someral director, page 2 should In. To Be Completed	examiner?	Hospital: 1 Inpatier	nt 2 ER/Outpatie		of Death (Check of Other) Nursin		Residence 6 🗸 Ott	ner: Scene
n of \ding Phy.	27. Manner of Death	28a. Date of Injur (Month, Day, Ye	y 28b. Time o		ry at Work?	28d. Describe ho	ow injury occurred	
Division tal or Attendii rs after death. al Director: led in by the fu	2 Accident Inves	stigation	ury - At home, farm, st		res 2 No	20f Logotian (St	troot and Number or	Rural Route Number, City
Division of spital or Attending I ours after death. neral Director; After filled in by the fune. Certification:		mined (Specify)	ary - At Home, farm, 3t	reet, ractory, office b	unung, etc.	or Town, Sta		Rural Route Number, City
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi Medical Certification: To Be Completed by Physician/Medical E	,	nysician. To the best of my	_				* '	
(y Z	29b. Signature and title of certifie	and manner stated.		29c. Licens	e number		29d. Date signed (A	fonth, Day, Year)
1 Shang	Calris	18/1	7	0.0.1	И.E.		February 2, 20)9
	30. Name and address of person Zabiullah Ali, M.D.	who completed cause of de Assistant Medical Ex		enn Street, Balti	more, MD 212	201		
State	31. Date filed (Month, Day Year)	2009 32 Registrar	's Signature					
Registrar	17000	CUUT JAHARAA	1 1. 130	A. S. A.				

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 U U 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 7:05 A.M William J. Metzger 5. 2009 /Medical February 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 315 - 15th Avenue Baltimore Anne Arundel 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 2 M 2 □ F 73 213 32 3568 Director May 2, 1935 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Evantmer must be notified at 1 ☐ Yes 2 🕱 No Director Baltimore Anne Arundel Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21225 315 - 15th Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: ģ Specify: 3 X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Magnes. Elementary/Secondary (0-12) 12th College (1-4or 5+) Sheet Metal Worker Coast Guard Yard 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fred W. Metzger Noralee Jenkins ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven Metzger / Son 6101 Kyle Leaf Court Elkridge, Maryland 21075 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 02/09/2009 Baltimore, Maryland Cedar Hill Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Gonce Funeral Service, P.A. manueally 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. attending physician Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 1 ☐Yes 2 No 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) To the Hospital or Attending Physicis within 24 hours after death.
To the Funeral Director: After this ce Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 124 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street Softanore Year) Registrar's Signature 31. Date filed (Month, Day, State 6 Registrar

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		For State		State of Ma	arylan		partment of h		Mental Hy	/giene	9	
		Registrar	/Fina Middle /			C	ertificate of	Death	T =	Reg. No	2009	03425
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/Medic Examin			DENISE N	TILES ive street and number)		-	4b, City, Town, o	or Location of Death			4, 2009	
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or 28	Director	10e. Street and Nun	nber				10f. Zip Code			10g. Cit	tizen of What C	ountry?
filed within 72 hours after death with the Maryland Hygiene. vither than "natural", or Items 23a or 28a-f show ent, the Medical Ex. miner must be notified at	Funeral		M AVENUE	12. Was Decedent	Ever in LL	2 10	207		nosify Voc or N		ITED ST	
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2 should be and Mental is marked c		19a. Informant's Na	me/Relationship	(Type. Print)		19b. Ma	iling Address (Street	and Number or Ru	ral Route Numi	ber, City o	or Town, State,	Zip Code)
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permit. Departr Importa any Injo		MAN	20/	DONALD R.	GRAY		22. Name and Addre IARSHALL'S 308 SUITI	FUNERAL	HOME O	F MA	RYLAND,	INC.
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ysiclan: is certific	To Be	examiner?		Hospital: 1 ☐ Inpatie	nt 2 □ E	R/Outpation	ent 3 DOA Oth	26. Place of Deal			6 □Other (Spe	noify)
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tending eath. tor: A the fu	catic	2 ☐ Accident	investigati	on			M 1	Yes 2 □ No				
or At after d Direct in by	Certification:	4 ☐ Homicide	determine				street, factory, office		28f. Location (City or To			ural Route Number,
spital		29a. Certifier	Certifying F	Physician: To the best of	of my know	vledge, dea	ath occurred at the ti	me, date and place.	and due to the	cause(s) and manner a	s stated
To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funeral process.	Medical	one)	2∐ Medical Ex	aminer: On the basis of and manner sta	examinati ated.	ion and/or	investigation, in my	opinion, death occu	rred at the time	, date an	d place, and du	e to the cause(s)
Within to the company of the company	M	29b. Signature and	title of certifie				29c. Licens	se number		29d. Da	te signed (Mon	th, Day, Year)
9		1) <	istant	2-00			146	6665		Tel	ruary	5, 2009
		30. Name and addre	ess of person wh	o completed cause of de Cuske Do	eath (Item	23a) (Type	e, Print)	0 ,	10.4-	MA	0000	,
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/Medical Examiner **Funeral**

Care Center <u>Villa Assumota</u> Baltimore
If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 1 □ M 2 🗓 F Months Days Hours Min. **Director** 175-24-6575 July 24, Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If frem 27 is marked other than "natural" or least any injury or other traumatic event 10a. State 10b. County 10c. City, Town or Location Completed by Funeral Director Maryland | Baltimore Stevenson 10f. Zip Code 21153 <u>1531 Greenspring Valley Road</u> 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher 17. Father's Name (First, Middle, Last) Be ၉ McMonigle Frank Mary 19a. informant's Name/Relationship (Type. Print) Sr. Marian Schaechtel Friend 20b. Place of Disposition (Name of cemetery, crematory or other place)

Sisters of Notre
Dame de Namur Cem.

22. Name and Address of Facility 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-5-2009 ove of Funeral Service Licensee 21. Sigr 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** neumon disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 3 Ectopic pregnancy 5 Other (specify) signed by the a P.O. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ Be Completed 24a. Was an 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home Hospital: Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Dete of Injury (Month, Day, Year) 1 Naturai 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the f 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral I 29a. Certifier Medical and manner stated. 29b. Signature eddress of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2009 03426 1 - State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 10:50 PM February 2009 Francis <u>McMonigle</u> Marie 4a. Facility Name (If not institution, give street and number)
Maria Health 4c. County of Death 4b. City, Town, or Location of Death Baltimore Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1928 Pennsylvania 10d. Inside City Limits 1 ☐ Yes 2 No 10g. Citizen of What Country? U.S.A. Race - American Indian, Black, White, etc. Specify. White 16b. Kind of Business/Industry Catholic High School 18. Mother's Name (First, Middle, Maiden Surname) Rose Fitzgerald 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21153 1531 Greenspring Valley Road Stevenson, Maryland 20c. Location - City or Town, State Ellicott City Maryland Ruck Towson Funeral Home, Towson, Maryland Approximate Interval Between Onset and Death Week 23d, Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 ☐ Yes 2 No 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) [OWSON, MD 21204 Suite 312 202 Drive 31. Date filed (Month, Day, Year) 32 Registrar's Signatu State 6 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Feb. 3, 2009 **Physician** 2:00 Josephine Frances /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Glen Arm 4217 Manorview Road 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Mary land If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 ☐ M 2**X**CXF 1925 83 219-10-3876 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Mydical Evan The Traumatic event, the Mydical Evan The Traumatic event, the Mydical Evan The Traumatic event, the Mydical Evan The Traumatic event, the Mydical Evan The Traumatic event, the Mydical Evan The Traumatic event, the Mydical Evan The Traumatic event, the Mydical Evan The Traumatic event, the Mydical Evan The Traumatic event, the Mydical Evan The Traumatic event, the Mydical Evan The Traumatic event and The Traumatic event e 10a. State 1 ☐ Yes 2X No Director Glen Arm Baltimore Md 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21057 USA 4217 Manorview Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🙀 No Specify: ģ White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Local Businesses Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marv Deppe Fernandis J. Bowen, Sr. ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4217 Manorview Road Glen Arm, Maryland 21057 William C. Mank/Husband Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State John's Hydes Cem. 2/7/09 Hydes, Maryland St. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licens Towson, Maryland 21204 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LNS **Physician** disease or condition /Medical resulting in death) Examiner Sequentially list conditions, Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physician and s the burial-trans Due to (or as a consequence of): Physician/Medical signed by the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death in the past 12 months 1 Yes 2 No 3 ☐ Ectopic pregnancy Month Day 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t lirector, page 2 s autopsy 1 ☐ Yes 2 🗆 No 1 ☐ Yes this certifical 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work?

Hospital or Attending Physiclan: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

124 hours after death.

e Funeral Director; After thioletely filled in by the funeral

Natural 2 Accident 5 ☐ Pending investigation 6 ☐ Could not be 3 ☐ Suicide determined

4 Homicide 29a, Certifie

29b. Signature and title of certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

McCornide

 Registrar's Signature Year 31. Date filed (Month, Day,

State Registrar

Medical

within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month 420 **Physician** Charles L. Malone 3 P005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner FRANKLIN SQUARE HOSPITAL CENTER BalTimore Rosedale If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, April 18, Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 XM 2 ☐ F Days Min. Months Hours 83 218-18-3929 Maryland **Director** Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Baltimore Maryland N/A tXXYes 2□No Director Charles 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21224 7119 Baltimore Street Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∏Yes 2 ∏ No IfYes, Give Year or Dates: 1XXNever Married 2 ☐ Married Maryland 21215-0036 Korea 1 ☐ Yes 2 No δ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Malone Elementary/Secondary (0-12) 9th College (1-4or 5+) Warehouse Worker Howard Johnsons 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi Ida Mae Wertz John Joseph Malone 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) es 1 and 2 sh of Health and item 27 is n 3102 Dubois Avenue Parkville Maryland 21234 Joyce Malone/Niece Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Woodlawn Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If iter 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 02/06/09 Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21. Signature of Funeral Service Licensee any 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Sepsis resulting in death) /Medicai Due to or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Decade of many that initiated events Due to (or as a consequence of) Examine ng physician and as the burial-tran P.O. Box 68760, 🖄 resulting in death) Last Due to (or as a consequence of) Physician/Medical the attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Por Month Day Year 5 ☐ Other (specify) ☐Yes 2 No detached 9 Unknown 9 I Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has page 2 s autopsy certificate 2 No Division of Vital 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 10 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 3 Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DO065091 NOUTER 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

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31. Date filed (Month, Day, Year)

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NGUYEN

9000 FRANKLIN Square

32. Registrar's Signature

DR

Balto

Amend 20b, per Fh G888 Type of Brint in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 03429 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 8-40 PM anns /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 24 Hrs. 8. Date of Birth Hours Min. Sept. 29, Vest Nursing and If Unde Birthplace (State or Foreign Country) **Funeral** 1 M 2□ F Months Days Maryland Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Expression must be notified at 1 ✓ Yes 2 ☐ No Funeral Director more 10e. Street and Number 10g. Citizen of What Country? items 23a X Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 6 1 ☐ Yes 2 ☐ No Specify. Completed by 3 Widowed 4 □ Divorced Blac "natural" 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Be item 27 is marked o ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son) Pages 1 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 2/1772009 20c. Location - City or Town, State Department of Important: If it any injury or o 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Fadility Joseph L. Russ cseph L. Russ 222 W. North Funeral Home f. tve. Barto. Må Ave 23a. Par[1] Enter the wease, or complications that cured the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shief, or heart thrue. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ordio voscular disesse **Physician** Sc disease or condition resulting in death) /Medical as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed Box 68760.53 and Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) P.0. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🛣 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate of Vital 2 No 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA nours after death.

neral Director: After this
filled in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 32. Registrar's Sign 31. Date filed (Month, Day, Year, State 6 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 03430 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 8:30A Forwary 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 7163 Greenwood Avenue Baltimore County 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 M 2 □ F 213-32-7525 74 Yrs July Director 3,1934 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits 28a-f show nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla artment of Health and Mental Hyglene. ortant: If item 27 Is marked other than "natural", or Items 23a or 28a-f show in Jury or other traumatic event, If a Pedical Examiner must be notified as injury or other traumatic event, If a Pedical Examiner must be notified as 1 ☐ Yes 2X No Director Maryland Baltimore Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21206 USA 7163 Greenwood Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. 11. Marital Status 1 Yes XX No If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2XXNo Specify Specify: ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Metropolitan Transit Elementary/Secondary (0-12) College (1-4or 5+) Authority Mechanic 9 yrs. N/A18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mildred Hepdina Aldrich McCleary ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy M. McCleary (Wife) 7163 Greenwood Avenue Baltimore, Maryland 21206 Department of Heal Important: If item 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition ₩ Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem. 2-6-2009 Baltimore, Maryland ²² Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Signature of Funeral Service Dicensee Cathon Approximate Interval Between Onset and Death 23a. Part 1. Enter the dise ext, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final injarc too **Physician** disease or condition resulting in death) /Medical ndiovancular duseane Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sician and burial-transit that the death certificate be exec Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No ed by the a 9 Unknown 9 Unknown signed by t ath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an has autopsy performed? 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie delphia Rd #304 Ballimore MD 21237 30. Name and address of person who completed cause of death (Item 23a) (Type

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Month 6:15 Claude Mayo February 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death sinal hospital of bottimore Cit Buttimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8-3-1923 Birthplace (State or Foreign Country) Months Days Hours Min. 1 ☑ M 2 🗆 F 85 N.C. 246-18-0415 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD N/A Baltimore XXYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5502 Ivanhoe Avenue 21212 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 XNo Specify Specify: Black 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore County 5th grade N/A Janitor Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willie Bessie Barnes Mayo 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Delores A. Moore-Daughter</u> 70 N. Orchard View Drive Hanover, PA 17331 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State Nation 3 ☐ Removal from State MD National Mem 2-7-2009 Laurel, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, MD 21202

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans attending p ned by the cate has been sign page 2 should be

Division of Vital Records, P.O. Box 68760,

24 hours after death Funeral Director: filled in by the

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

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Funeral

Director

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Modical Evanine must be notified at once.

Physician /Medical

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21215-0036

Maryland

Baltimore,

shock, or heart failure. List only or	cations that caused the death. I ne cause on each line.	Do not enter the m	ode of dying, such as car	diac or respiratory arrest,		Approximate Interval Between
Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequen		lure			Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enier Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequen	ice of):				Iweik
that initiated events 'resulting in death) Last	Due to (or as a consequen					Tweek
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat 9 ☐ Unknown	eath 3 Ectopi	c pregnancy (specify)		23d. Date of de Month	elivery Day Year
Part II. Other significant conditions cor	Cancer			23e. Did tobacc		to the cause of death? Probably 4 🗌 Unknown
Cardiomycpal	ly atrial	fibrillat	er-	24a. Was an autopsy performed	prior to death?	tutopsy findings available completion of cause of s
25. Was case referred to medical examiner?				Death (Check only one)		
11 Yes 2 No	ospital: Inpatient 2 ER/	/Outpatient 3 □	DOA Other: 4 Nursin	g Home 5 ☐ Residence	6 ☐ Other (Spe	ecifv)
27. Manner of Death	28a. Date of Injury (Month, Day, Year)	b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how in	jury occurred	
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, street, facto	ory, office	28f. Location (Street City or Town, St	and Number or F ate)	lural Route Number,
29a. Certifier Certifying Phys	ician: To the best of my knowle ner: On the basis of examination and manner stated.	dge, death occurre and/or investigati	ed at the time, date and pl on, in my opinion, death o	ace, and due to the cause ccurred at the time, date	e(s) and manner a and place, and du	as stated. e to the cause(s)
29b. Signature and title of certifier		2	9c. License number		Date signed (Mon	
Roishy Grai			RES - OC	of Baltime	ébruog	3,2009
30. Name and address of person who co		Sa) (Type, Print)	Hospital e	& Baltime	re	

State Registrar

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Hospital

on MP

32. Registrar's signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician McMillan 02:10 PM Josephine 2009 blugen 01 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore Union Memorial Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 921 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2√2√x Months Days Hours Min. W. 216-20-1060 87 VA Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Modical Exament in ust by notities at Baltimore MD N/A 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturo" any hiury or other traumatic our once. 21218 2200 Homewood Avenue S A Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian, Black, White, etc. Armed Forces?
1 ☐ Yes 2 🕱 No 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: XXNever Married 2 ☐ Married Specify: Black 1 ☐ Yes 2X No Specify 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bremar Private 6th grade N/A Cafeteria Worker School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Virginia Ward McMillan ၉ Clarence 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 764 Barlett Avenue Balto, MD Carolyn Jones-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Spurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery 2-6-2009 Balto Co, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H E. North Avenue Balto, 1101 MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner law requires that the death certificate be executed use as the burial-trans and resulting in death) Last Box 68760. physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? for Month Day Year 5 ☐ Other (specify) signed by the a P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has N autopsy performed? Yes 200 No page 1 ☐ Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 🗆 Yes 2 No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) AT2438946

State

Registrar DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RGD

FEO 31. Date filed (Month, Day, UNION MEMORIAL

State of Maryland / Department of Health and Mental Hygiene 03433 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** FRED ROBERT MILLS FEBRUARY 2009 8:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death FOREST HILL HEALTH & REHAB CENTER FOREST HILL HARFORD If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1 X M 2 □ F Hours Director 218-18-7541 85 23, 1923 West Virginia Usual Residence of Decedent the Maryland 10c. City, Town or Location 10b. County 28a-f show 10d. Inside City Limits Examiner must be notified at Director 1 ☐ Yes 2 🛣 No Maryland | Harford Fallston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 5 items 23a 711 Reckord Road 21047 USA Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Yes 2 No if Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☑ No Specify þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Dairy & Beef Farming Farmer 7 is marked other traumatic event, t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Wesley Mills Chloe Jane Hamrick 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2::
Department of Health a.
Important: If Item 27 is any injury or other trauonce. Sharon Baxley / Daughter 715 Reckord Rd., Fallston, Maryland 21047 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 Other (Specify Air Memorial Gdn: 2-9-09 Bel Air, Maryland 21. Signature of Fundral Service I 22 Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or color calors that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** multifue 1 /Medical Due to (or as a consequence of): Examiner soulle Sequentially list conditions, if any, is a ling to transcitate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exist to for as a ponsequence of The law requires that the death certificate be executed Exami bunal-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No autopsy certificate perform 2 🗆 No 1□ Yes or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nersing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending Injury investigation 2 Accident 1 ☐ Yes 2 ☐ No after death filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D35522 5 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18 DAVID DUNN 615 W. MACPHAIL ROAD 21014 BEL AIR, MD. 31. Date filed (Month, Day, Year) 32. Registrar's Agnature State Registrar 6

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day ladser Year Month **Physician** Ca 11: 00AM 2009 /Medical however 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital Agnes Himor SAINT If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days 1 □ M 2 1 Nune Director Invary 18 2009 Usual Residence of Decedent 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits show ir than "natural", or items 23a or 28a-f sho 1 ☐ Yes 2 No Director umDi9 owar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21046 United 0130 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 □Yes 2 No If Yes, Give Year or Dates: Saltimore, Maryland 21215-0036 Specify: Mother 1 Yes 2 No White Specify: 3 Widowed 4 Divorced Per Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Infant none of the and Mental Hygic Ith and Mental Hygic Ith and I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be vargas ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a -Avenue Baltimore permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr Giselle Montero Maryland mo 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 22. Name and Address 17 blumbiaPik Didl 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. pproximate Interval Between Onset and Death Immediate Cause (Final **Physician** Extreme Premotor disease or condition resulting in death) /Medical Due to (or as a consequence of): 5 Weck 5 Examiner rolonged 5 days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pital or Attending Physician: The law requires that the death certificate be executed ours after death.

eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋧ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 🗆 No 2 No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 🗆 No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 18 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Avenue 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 6 2009 Registrar

09-00954 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 03435 Frederick Nicholson 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day February 1, 2009 0456 hrs Medical Examiner Frederick Nicholson 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Sinai Hospital **Baltimore** If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min Director Country) 1 X M 2 219-26-8920 69 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No must be notified at once. Baltimore Owings Mills urs after death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 9311 Lyonswood Drive Funeral 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 2 Never Married **X**Married Yes 2 X No imore, MD 21215-0036

Pages 1 and 2 should be filed within 72 hours after de nent of Health and Mental Hygiene ant: If item 27 is marked other than "natural", or or other trannante event, the Medical Examiner un Black 3 Widowed Yes, Give Yea Yes 2 X No specify: Specify. Divorced \$ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 12th grade Wire Wrap Technician Northrup na Grismman 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frederick Nicholson Viola Swift 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21117 19a. Informant's Name/Relationship (Type, Print) Barbara Jean Nicholson Owings Mills, 20c. Location - City or Town, State Lyonswood Drive, permit. Pages 1 and 2 Department of Health a Owings 20b. Place of Disposition (Nam 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State tant: King Memorial Park 2/7/09 Woodlawn, Md Donation 5 Other Specify: Signature of Funeral Service License 22. Name and Address of Facility
March F/H West Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. 21215 Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death Complications of necrotizing cholecystitis Immediate Cause (Final disease xamine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examine (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last Physician/Medical 23a, PII, 27, perME, g890 4/8/09 TT fing physician a X UNPENDED AMENDED Box 68760. 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Day Year past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o ≥ Hypertensive atherosclerotic cardiovascular disease; Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a. Was an 24b. Were autopsy findings available Morbid obesity; hepatitis; chronic obstructive prior to completion of cause of autopsy has performed? death? ✓ Yes 2 2 No <u>pulmonary</u> disease 1 Yes 26.Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: within 24 hours after death. Vital Be examiner? Other₄ Hospital: 1 ✓ Inpatient 2 DOA Nursing Home 5 ER/Outpatient 3 Residence 6 this 2 1 ✓ Yes ₹ o 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 X Natural Yes 2 Pending Director: ad in by the f Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier isk O.C.M.E February 3, 2009 Drassel

Dend

DHMH 17 Rev 1/2001 **OCME 2006**

State Registra

OCME

Assistant Medical Examiner

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

Melissa Brassell, MD

31. Date filed (Month, Day, Year)

ORIGINAL

111 Penn Street, Baltimore, MD 21201

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death _200^{Year} **Physician** February Charles W. Namuth, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Towson Gilchrist If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Ye 1/22/1921 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days XXM 2□F Maryland 219-01-5109 88 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it at Medical Examinational be notified at Timonium 1 ☐ Yes 2XXNo Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21093 USA 12261 Roundwood Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Proces: No WWII Black White etc. MXYes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 □ Yes 2√2 No Specify: ģ Specify: 3 Widowed 4 □ Divorced White and Mental Hygiene. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) B & O Railroad Stenographer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marie Sauerwein Charles W. Namuth, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2 Elphin Ct. Unit 101 Timonium, Maryland 21093 Margaret Christenson/ Stepdtr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/10/2009 Garrison Forest Cem. Baltimore, Maryland 22. Name and Address of Facility Towson, Maryland 21204 21. Signature of Funeral Service Licenses 1 Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician NEUMONI DAUS disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter or denying Cause (Disease or injury Due to (or as a consequence of): Examine certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical attending | IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant. Live birth 2 Fetal death 3 Ectopic pregnancy Day in the past 12 months? Month Year õ 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No detached o 9 Unknown signed by t ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed DIABETES 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐Yes 2 ☐ No APLASTIC ANEMIA 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HISFICE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA spital or Attending Physiours after death.
neral Director: After this y filled in by the funeral di Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Dav. Year) D64395 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6565 N CHAPLES ST. SUITE 209 BALTIMORE, MD 21204 DOBERMAN, MO DANIEUE

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death INCEN FEBRUARY 8:42 PM 2009 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death UNIVERSITY BALTIMORE OF MARYLAND MEDILAL CENTER 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) SEP 12 1941 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Months Days Hours New York 082-32-7128 67 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County Catonsville 1 ☐ Yes 2 No MD Baltimore 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 21228 USA 4 August Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: 60-62 Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) **Office** Elementary/Secondary (0-12) College (1-4or 5+) Equipment & Supplies Business Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Theresa DesiMone J. Orlandi **Vincent** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Catonsville. MD 21228 19a. Informant's Name/Relationship (Type. Print) 4 August Avenue, Catonsville, MD Jean Orlandi - wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 02/05/2009 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensen H. Williams MacNabb Tuneral Home, P.A. Hule 301 Frederick Road, Catonsville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACUTE MY ELOGENOUS LEUKEMIA REFRACTORY Due to (or as a consequence of) Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 No 2 X No 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28d. Describe how injury occurred

Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and P.O. Box 68760, physician the attending for use ed by the detached signed by Division of Vital Records, cate has been signated by page 2 should b this After nours after death.

neral Director: Af

filled in by the fur

Examiner Physician/Medical 2 Completed Be Certification: To

Medical

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

Be

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ir than "natural", or items 23a or 28a-f show

and Mental Hygiene.

permit. Pages 1 and 2 s Department of Health al Important; If item 27 Is any Injury or other trau once.

Physician /Medical

Examiner

filed within 72 hours after death

Pages 1 and 2 should be

Baltimore, Maryland 21215-0036

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 1 Naturai 2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

within 24 hours a

To the Funeral I State

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year) 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

O. AJE. 22 SOUTH GREENE ST. BALTIMORE, MD. 21201

31. Date filed (Month, Day, Year)



Registrar

09-00938 Joseph A. Ortiz Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

03438

1555		1- For State Registrar	Certificate of		ia monta		g. No.) 0040
Physiciaı ledical Examin		Decedent's Name (First, Middle,Last) Joseph Ant	hony Ortiz	Z	- X E Y E	2. Date of Death Month February 1	Day Year , 2009	3. Time of Death . 1831 hrs
		4a. Facility Name (if not institution, give street and number) 1385 Blue Ball Road		b. City, Town, o	r Location of E		4c. County of Death Cecil	
Funeral Director		222-50- 7588- 1 M 2 F	yrs. last birthday) 44 Yrs.	If Under 1 Ye Months Day		Min.	Foreig	thplace (State or gn untry) DE
Maryland 28a-f show any d. at once.		MD Cecil	. City, Town or Locati	on	EI	kton		10d. Inside City Limits 1 Yes 2 No
the Mary	ā١	10e Street and Number 1385 Blue Ball Rd.		10f. Zip Code	21	921	g. Citizen of What Cou	ntry? U.S.A.
ral",	by Fune	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed)	No If Y	es, specify Cuba	n, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Amer White, etc. Specify:	white
036 ithin 72 hou ne. r than "nat ledical Exa	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during me	ost of working life		e retired)	X	munications
215-0036 be filed within 7 mtal Hygiene. rked other than vent, the Medica	Be Co	17. Father's Name (First, Middle, Last) Elpidio Or				Name (First, Middle, M	Frances Atkin	
MD 21 d 2 should lith and Mer n 27 is man	٩	19a. Informant's Name/Relationship (Type, Print) Lisa Cahill-Bond Sister				or Rural Route Num Ownsend, DE	ber, City or Town, State 19734	e, Zip Code)
Baltimore, lemit. Pages I and Department of Heal Important: If tien injury or other tra		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:		ner place) rematory Se	ervices	Date Q-Q-09		Town, State
		7. Signature of First and Cervice Lidensee	293 ^{22. N}	Address Krien	en-Griffith Kirkwood	Funeral Homes Hwy. Wiloming	ton, DE 19805	
Physician /Medical xaminer		23a. Part I. Enter the disease, or complications that caused the failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a conseque	rotic card				est, shock, or heart	Approximate Interval Between Onset and Death
	آو او	Sequentially list conditions, if any, leading to immediate b. Due to (or as a conseque	nce of):					
Insit ted.	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a conseque d.	nce of):					
760, crate be executed physician and the burial - transit	Medical	X UNPENDED X AMENDED 23a, 2 10e, 19b pe	27,perME, er fh g88	G888 2/ 8 2-20 -	12/09 ' -09 vt	TT// #5 pe	rFh g8904/2	24/09 TT
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of 1 Live birth 4 Pregnant at time g	2 Fe	tal death 3 ner (Specify)	Ectopic pr	regnancy	23d. Date of deliver Month	y Day Year
ires that the daires that the daired by the	2	Part II. Other significant conditions contributing to death but	not resulting in the u	nderlying cause	given in Part I		bacco use contribute to	
of Vital Records, ng Physician: The law requir ther this certificate has been simeral director, page 2 should	Completed					24a. Was a autop: perfor	sy prior to oned? death?	utopsy findings available completion of cause of es 2 No
Vital Rec	Be C	25. Was case referred to medical examiner?		26.Plac		neck only one)		handanii .
f Vir	٥	1 ✓ Yes 2 No Tospital 1 Inpatient	2 ER/Outpatient 28b. Time of Ir	Assessment	Other ₄ N		Residence 6 Othe	r: Scene
ISION OF Attending Pl or death. rector: After i		27. Manner of Death 1 X Natural 2 Accident 5 Pending Investigation 28a. Date of Injury (Month, Day, Year)	Zob. Time of h		Yes 2 N	1	iow injury occurred	
Division pital or Attendious after death. reral Director: /filled in by the fi	Certification:		- At home, farm, stree	et, factory, office	building, etc.	28f. Location (S or Town, St		ıral Route Number, City
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	_	29a. Certifier 1 Certifying Physician: To the best of my knot one) 2 Medical Examiner: On the basis of examina and manner stated.	-					
	žΓ	29b. Signature and title of pertifier			se number .M.E.		29d. Date signed (Mo February 2, 2009	
Ø		30. Name and address of person who completed cause of death Laron Locke MD. Assistant Medical Examil	,	Street, Balti	more, MD	21201		
Sta Registr	_	31. Date filed (Month, Day, Year) 32. Registrar's S	ignature					

			For State Registrar	State of Ma	ryiani	•	rtificate of			иентаг пу	Reg. N							
	Physici	an	1. Decedent's Name (First, Middle, Last LEONA Z.	PEAF	CE		·· <u>·</u>			2. Date of De	eath	ay	Year	3. Time of Death				
and.	/Medic Examin	cal	4a. Facility Name (If not institution, give		(CE		4b. City, Town, o	r Locatio	n of Death	Jebn	1	y 5 e. County	2009 of Death	1:22 M				
AB *	Funeral Director	ler	Franklin Sags. Social Security Number 6.5	ware Ho	SP1 (In yrs. 1a 79	ast birthday) Yrs.	ROS If Under 1 Year Months Days	ed	oler 24 Hrs.	8. Date of Bir (Month, Did 12-21		Ba	9. Birthp	MONE lace (State or Foreigr try) YLAND				
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	eation						10	Od. Inside City Limits				
	a-f sho	ctor	MD BALT	IMORE			RC	SED	ALE					1 □ Yes XXNo				
	th with the 23a or 28	Funeral Director	10e. Street and Number 1408 LANCELOT	DRIVE			10f. Zip Code		2123	7	10g. C	itizen of V	Vhat Coun U	ry? .S.A.				
036	be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at		11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☐ YNG If Yes, Give Year or Dates:			Vas Decedent of H fYes, specify Cub □Yes 2□★0	lispanic an, Mexi Spec		pecify Yes or No Rican, etc.)	0-		e - Americ k, White, e					
Maryland 21215-0036	within 72 ho iene. than "natui ne wedicel	Completed by	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+		(Give life. L	lent's Usual Occup kind of work done DO NOT use retired TY CONT	during m d)					SDMT					
5	filed v I Hygie other I	Be Co	17. Father's Name (First, Middle, Last)			QUALI	II CONI			e (First, Middle				CK & CO.				
ylan	should be and Menta s marked umatic ev	To B	ANDREW	ZACHARSKI	· ·				NA ————				CYJK	<u>.</u>				
Ma'r	ges 1 and 2 should it of Health and Mer If item 27 is marke or other traumatic		19a. Informant's Name/Relationship (JO ANN GURFOLI		ER		g Address (Street LANCEI				-	or Town, OALE	-	Code) 21237				
ore,	es 1 ar of Hea fitem 2		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □				sition (Name of natory or other place			Date			City or To					
Baltimore,	t. Pa rtmer rtant:		4 □ Donation 5 □ Other (Specifi	<i>(</i>)	ST		NISLAUS		•				K, M					
Ba	permi Depa Impo any Ir	l II	21. Signature Lice	see			211 CHE					LE,		ERAL HOM 21237				
P.	Physician /Medical		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	olications that caused to one cause on each line a. Due to (or as) (EXAC	er the mode of dyin	W		or respiratory a	arrest,			Approximate Interval Between Onset and Death				
	Examiner up up up up up up up up up up up up up	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a	consequ	ence ofj:												
68760,	tificate be executed g physician and as the burial-transit	edical Ex	resulting in death) Last	Due to (or as a	consequ	ence of):												
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit				Physician/Me		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ √00 9 □ Unknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	Fetal	death 3	Ectopic pregnand Other <i>(specify)</i>	:y				23d. Dat Mo	e of delive nth	ry Day Year
rds, P.	quires that n signed b ıld be deta	by	Part II. Other significant conditions of	ontributing to death but	not resu	lting in the un	derlying cause giv	en in Pa	rt I.	23e. Did		use contr		e cause of death? ably 4 ☐ Unknown				
Vital Records,	The lar ate has page 2	Completed								24a. Was auto perfo 1 ∐Yes		, p	Vere autoporior to cor leath?	osy findings available npletion of cause of 2 No				
	siclan: The certificate lirector, pag	B	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1⊠Inpatien		ER/Outpatien	Oth	or:		h (Check only		0 [] ()						
on of	Attending Physician: r death. ector: After this certific by the funeral director, I	ion: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day,		28b. Time of Injury	28c. Injui Wor	ry at k?		ome 5 Resi				<u> </u>				
Division of	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification: To	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		y - At hoi (Specify	me, farm, stre		Yes 2	□No	28f. Location (City or To	Street a wn, Sta	and Numbi te)	er or Rurai	Route Number,				
	To the Hospital or Attene within 24 hours after death To the Funeral Director: completely filled in by the	Medical Co	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam	ysician: To the best of niner: On the basis of and manner state	examinat	wledge, death ion and/or inv	occurred at the tivestigation, in my	me, date	and place death occur	, and due to the rred at the time,	e cause , date a	(s) and mand place, a	anner as st and due to	ated. the cause(s)				
	To the withir To the comp	Me	29b. Signature and title of certifier				29c. Licens	se numbe	er		29d. D	ate signed	(Month, L	Day, Year)				
			30. Name and address of person who	ompleted cause of de-	ath (I+	222) /Time !	D (3	, 13		30	orua	My	5,2009				
	17 NA		DR Alab Pa 2 9(000 Frank	's Signat	Sayuar Sayuar	- 10	Bo	Utim	ore 1	1d	2	123	37				

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician hyllis Patro 12:35AM 2 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 10 WHITE SAIL CIRCLE BERLIN WORCESTER 7. Age (In yrs. last birthday) 62 Yrs. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 1 – 1 4 – 1 9 4 7 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F Days MARÝLAND 218-46-9605 **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show 1 ☐ Yes 🏖 ☐ No Funeral Director MD BERLIN WORCESTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 WHITE SAIL CIRCLE U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME Pages 1 and 2 should be filed w triment of Health and Mental Hygie rtant: If item 27 is marked other t hiury or other traumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **JAMES** CARLINO ROSE (FRANCHAPANI) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau GEORGE PATRO / HUSBAND 10 WHITE SAIL CIRCLE BERLIN, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MID SHORE CREMATION 2-2-09 CAMBRIDGE, MD 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee 1211 CHESACO AVE ROSEDALE, MD 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy performed? 1 □Yes 2 ☑No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 5 Residence 6 \subseteq Other (Specify) 1 Yes 2 YNo Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Watural 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No s after death. 2 Accident 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral 29a. Certifier 17 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. To the I within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier) 030690 M.O Feb. 2 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARTIN E. Corroll St. 501.860, MO 21801 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 0 6 2009 Registrar

	1	For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of F <i>rtificate of I</i>			giene Reg. No. 20	109	03441
Physiciar		1. Decedent's Name (First, Middle, Las	t)	- · -			2. Date of Dea	Day	Ye ar	3. Time of Death
/Medica		Sherman Pe	etroot and number)		4h City Town o	r Location of Death	February	4c. County	009	11:45 AM
Examine		3506 Goldenro			Parkv			Balti		
Funeral Director		231-30-1414	ex 7. Age XIM 2□ F	(In yrs. last birthday, 58 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day 02/13/1	y, Year) 9 50	9. Birthp Cour Sout	place (State or Foreign ntry) h Carolina
Maryland f show	t	Usual Residence of Decedent 10a. State 10b. County MD Baltin	nore	10c. City, Town or Lo					1	10d. Inside City Limits 1 ☐ Yes 2 📉 No
fter death with the Mary ritems 23a or 28a-f sh	יו חוופר	10e. Street and Number 3506 Goldenrod	Lane		10f. Zip Code 21234			10g. Citizen of		ntry?
Irs a	2	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E- Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates:	0	Was Decedent of H If Yes, specify Cuba 1 □Yes 2 No	Specify:		14. Ra Bla Specif	ce - Americ ck, White,	etc.
d within 72 h giene. ir than "natu	nataidillo	15. Decedent's Edi (Specity only highest grad Elementary/Secondary (0-12) 1 2	ucation de completed) College (1-4or 5+	.)	edent's Usual Occup e kind of work done DO NOT use retired Prations	11 4	~	16b. Kind of B		dustry
weld be filed Mental Hygarked othe atic event,	מ	17. Father's Name (First, Middle, Last) Willie Pee				18. Mother's Nam Catheri	ne (First, Middle, ne Willia		ne)	
and 2 sho ealth and n 27 is me eer traume		19a. Informant's Name/Relationship (7 Joe-Ann Legette		350	ng Address <i>(Street</i> 5 Golden			e, MD	21234	
Pages 1 ment of Hi ant: If iter ury or oth		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	Place of Disposition Place of	Nationa '	-, -	-	20c. Location	ce, S.	.C.
permit. Depart Import any Inj		21. Signature of Funeral Service Licen:	Elaus	E ²	2. Name and Addre Vans Fun 300 Harf	eral da ord Rd.	pel & Cre Parkville	mation , MD 2	Servi 1234	.œs
Physician /Medical Examiner		29a. Far 1. Enter in disease, or comp hock, or heart failure. List only of immediate Caus. (Final ease or condition resulting in death)	a. Purcu	e.	ter the mode of dyir	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death I + mDnth
	-Yallillei	Sequentially list conditions, if any, leading to immediate cause. Either underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):						
rificate be executed g physician and as the burial-transit			d							
attendir for use	II) SICIALI III	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at 9 ☐ Unknown	Fetal death 3	☐ Ectopic pregnanc ☐ Other <i>(specify)</i> _	у			ate of delive	ery Day Year
w requires that the d	, L	Part II. Other significant conditions of	entributing to death but	t not resulting in the t	ınderlying cause giv	en in Part I.				he cause of death?
ician: The law requires certificate has been sector, page 2 should								sy med? 2 ∑ No	Were auto prior to co death? 1 ☐ Yes	opsy findings available impletion of cause of 2 □No
hysiciar this certif		25. Was case referred to medical examiner? 1 ☐ Yes 2X No	Hospital: 1 ☐ Inpatier	nt 2 ☐ ER/Outpatie	nt 3 DOA Oth	er: 4 \(\sum \) Nursing H	th <i>(Check only or</i> ome 5 ∑ Resid		her /Snacii	
nding Phrath. r: After thi	acioni.	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day,	y 28b. Time o	of 28c. Injur Wor		28d. Describe h			<i>y</i> /
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.	ry - At home, farm, st (Specify)	reet, factory, office		28f. Location (S City or Tow		ber or Rura	al Route Number,
To the Hospital or within 24 hours after to the Funeral Director completely filled in I		29a. Certifier 1	ysician: To the best or liner: On the basis of and manner stat	examination and/or i	th occurred at the tinvestigation, in my o	me, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and m date and place,	anner as s and due to	stated. the cause(s)
with To the corm	A	29b. Signature and title of certifier	— hoai	ral Doctron	29c. Licens	0 (0 7 1°	_	29d. Date signe 'ebru <i>a</i> r		
t I		30. Name and address of person who of Dr. Amy DeZern,	ompleted cause of de M.D. 401	ath (Item 23a) (Type N. Broadw	Print)			1231		
State Registrar		31. Date filed (Month, Day, Year).	32: Registra	r's Signature	W					

09-00911	
Virginia Ponzini	

irginia Ponzini	State of Maryland / Departmen 1- For State Registrar Certificate		lygiene 200	9 0344
Physician Medical Examine	1. Decedent's Name (First, Middle,Last)	ziní	2. Date of Death Month Day Year January 31, 2009	3. Time of Death 0555 hrs
	4a. Facility Name (if not institution, give street and number) 7853 Sellner Road # 13	4b. City, Town, or Location of Deat Jessup		
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 11 M 2 X F 55	y) If Under 1 Year If Under 24Hr Yrs. Months Days Hours Min	s. 8. Date of Birth(MM/DD/YYYY) 9. Bit 10/01/1953 Co.	
Maryland 28a-f show any Lat once.	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Arundel Jessu 10c. City, Town or L Jessu	p		10d. Inside City Limits 1 Yes 2 No
th the Maryland 23a or 28a-f sho notified at once.		10f. Zip Code 20794	10g. Citizen of What Cou	intry?
or items	3 Widowed 4 X Divorced It Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert Yes 2X No specify:	o Rican, etc.) White, etc. Specify: Whi	
215-0036 be filed within 72 hours after that Hygiene "natural"; ket other than "natural"; ent, the Medical Examiner of Committed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 10th Nu	edent's Usual Occupation (Give kind of ng most of working life. DO NOT use re	ant Nursing	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 neut of Health and Mental Hygiene, ant: If lien 27, is marked other than or other traumatic event, the Medical	Raymond Edwin Triv	rett G:	e (First, Middle, Maiden Surname) Ladys Dowler	
MD 2 nd 2 shoul salth and M em 27 is m raumatic	Gladys McNeir / Mother 785	3 Sellner Rd. Lot	Rural Route Number, City or Town, State 13 Jessup, Mary Date 20c. Location - City or	land 20794
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Menal Hygiene. Important: If item 27 is marked other Unjury or other transmatic event, the Med T of the Me	1 Burial 2 X Cremation 3 Removal from State Bayview	or other place) Crematory 02/	03/2009 Baltimore	, Maryland
Physician Physician	21. Signature of Funeral Service Licensee 236. Part I. Enter the disease, or complications that caused the death. Do not en	4001 Ritchie Highw	nce Funeral Service ay Baltimore, Mary or respiratory arrest, shock, or heart	e, P.A. yland 21225 Approximate Interval
/Medical xaminer	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Methadone intoxic Due to (or as a consequence of):	ation		Between Onset and Death
led nisit	Sequentially list conditions, if any, leading to immediate course From Interriging Course (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of):			
o, e be execu ysician and burial - tra	X UNPENDED	8a-f, perME, G889	3/3/09 TT	
vision of Vital Records, P.O. Box 68760, or Attending Physician: The law requires that the death certificate be executed three death with death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial - transitification: To Ba Commissed by Directorian Madicial Existing the state of the physician Resident of the physician Resident of the physician Resident of the physician Resident of the physician Resident of the physician Resident of the physician Resident of the physician Resident of the physician Resident of the physician Resident of the physician Resident of the physician Resident of the physician Resident of the physician physician Resident of the physician physician Resident of the physician	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 4 Pregnant at time of death 9 Unknown	Fetal death 3 Ectopic pregn Other (Specify)	ancy 23d. Date of deliver Month	y Day Year
ires that the signed by the detache	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco use contribute to 1 Yes 2 No 3 Pro	
of Vital Records, ng Physician: The law require. ther this certificate has been signeral director, page 2 should by				utopsy findings available completion of cause of es 2 No
F Vital Republisher: The Physician: The rubis certificate all director, page To Re Cor	25. Was case referred to medical examiner? 1 Pospital: 1 Inpatient 2 ER/Outpa	26.Place of Death (Check tient 3 DOA Other Nursi	only one) ng Home 5 Residence 6 Othe	r: Scene
Division of spiral or Attending Pl hours after death neral Director: After filled in by the funeral Certification:		:45 am 1 Yes 2 X No	28d. Describe how injury occurred unk	
Di ospital hours a meral			28f. Location (Street and Number or Ruor Town, State) 7853 Sell Jessup, MD	
Diversity of the Hospital of white 24 hours at the Funeral Diversity filled completely filled Certifical Certi	(Check only one) 2 Medical Examiner: On the basis of examination and/or invessing and manner stated.	tigation, in my opinion, death occurred	at the time, date and place, and due to th	ne cause(s)
0 8	29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a)	29c. License number O.C.M.E.	29d. Date signed (Mo	пπ, ∪ay, Year}
	Margarita Korell MD. Assistant Medical Examiner 11	1 Penn Street, Baltimore, MD	21201	
State Registra	31. Date filed (Month, Day, Year) 32 Registrar's Signature	arked		

State of Maryland / Department of Health and Mental Hygiene 2003 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician 6/4PM February 2009 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner ATTO MI Aira Carro Cente If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country)
 MD Social Security Number 7. Age (In yrs. last birthday, **Funeral** Months 1 XM 2 ☐ F 216-22-2024 Ĩ927 81 Oct. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 □Yes 🌡 □ No MD Carroll Sykesville Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21784 6033 Old Washington Road USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Armed Forces:
1 Xi Yes 2 □ No
If Yes, Give
Year or Dates: 1945-47 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. ģ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Woodworking <u>Carpenter</u> 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carrie Shipley Roland Paynter P 19a. Informant's Name/Relationship (Type. Print)

Mrs. Kathleen A. Paynter (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6033 Old Washington Road Sykesville, MD 21784 19a. Informant's Name/Relationship (Type. Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2/9/2009 4 Donation 5 Dother (Specify) Brandenburg UMC Cemetery Svkesville, MD HAIGHT FUNERAL HOME & CHAPEL, P. PO Box 195 Sykesville, MD 21784 21. Signature of Funeral Service Licenses Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complic of ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examine be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. signed by the attending physician d be detached for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 4 ⊡Unknown 1 ☐ Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 - Matural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No after death Director; 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours at To the Funeral D 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Feinber RUSSEL AV year) 31. Date filed (Month, Day, Registrar's Signature State Registra

9-00882		Please Type or Print in Black Indelible Ink. Ensure All Copi	_	jible.	
erald Plummer		State of Maryland / Department of Health and Mental H	lygiene	200	9 1344
		1- For State Certificate of Death	Re	g. No.	J 001.
Physicia		Decedent's Name (First, Middle,Last)	Date of Death Month	Day Year	3. Time of Death
ledical Exami	ner	Gerald Plummer	January 30), 2009	0748 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deat	h	4c. County of Death	
		500 Mirabile Lane Baltimore		Baltimore Cou	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hr	_	h (MM/DD/YYYY) 9. Bir Foreig	
Director		216-58-0924 1X M 2 F 56 Yrs. Months Days Hours Mir	09/14/		untry) MD
		Usual Residence of Decedent	1	I. III	
any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
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Maryland 28a-f show 1 at ouce,	뒳	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Cou	ntry?
th the Maryland 23a or 28a-f sho uotified at ouce.	Director	500 Mirabile Lane 21224		USA	
s 232		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S	pecify Yes or No-		ican Indian, Black,
eath y	uneral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto	o Rican, etc.)	White, etc.	
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urs al tural	d b	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of		16b. Kind of Business/	
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215 be file ntal H rked o	Be (George Plummer Dorothy	J	Nodon	137
, MD 21215-0036 and 2 should be filed within 72 hou tealth and Mental Hygiene. tem 27 is marked other than "nat traumatic event, the Medical Exa	10	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or	ξ		
MD id 2 shouth and m 27 is an mati		Gerald T. Plummer, Jr. (son) 908 North Marlyn Ave	e. Esse	x, MD 21221	
e, F I and Healt item		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City or	
timore, MD 21215-0036 1. Pages I and 2 should be filed within 72 hours after death with the Maryland tment of Health and Mental Hygiene. rtant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other transmatic event, the Medical Examiner must be notified at once		Hillton Service Corn 102	/05/2009	Towson, M	arvland
Baltimore, MD 21215-003 pernit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other transmatic event, the Med		21. Name and Address of Facility Duc			
Dept Injurial					ndalk, Inc.
Physician		23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac			Approximate Interval
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xaminer		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):			
		Sequentially list conditions, b.			
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ox 687 eath certific tattending properties as the	icia	past 12 months? 4 Pregnant at time of death 5 Other (Specify)			
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Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Funeral Director: After this certificate has been signed by the attending physicitely filled in by the funeral director, page 2 should be detached for use as the built elled in by the funeral director, page 2 should be detached for use as the built pure the page 2 should be detached.	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		bacco use contribute to	
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Division To the Hospital or Attendin within 24 hours after death. To the Finneral Director: A completely filled in by the fin	Certification:	Suicide Could not be determined (Specific) house		treet and Number or Ruate) 500 mirat	ile Lane
Ospital ospital hours a nineral I		4 Homicide	Dundalk		
To the Hos within 24 h To the Fur completely	Sa	Chieck only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred			
To the within 2 To the complet	Medical	and manner stated. 29b. Signature and title of certifier 29c. License number	,	29d. Date signed (Mo.	
		O.C.M.E.		January 30, 2009	
		Tumel T Xuithall, Ml)		January 50, 2008	
		30. Name and oddress of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore,	MD 21201		
W			1VID 2 1201		
St Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registrar's Signature			
	المنتحد	- C. Jakes			

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2009 ear **Physician** FEBRUARY PLUMHOFF ATHLEEN 11:30 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 995 POINT PLEASANT ROAD GLEN BURNIE ANNE ARUNDEL 8. Date of Birth (Month, Day, April 24, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 F Months Days Hours Country 69 220-36-9970 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene.

Hygiene, "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location or 28a-f show event, the Medical Exaciliner must be notified at 1 Yes 2 No Glen Burnie Director Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21060 U.S.A. 995 Point Pleasant Road "natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 □Yes 2 No Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Optic Graphics Bookbinder 8 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If Item 27 Is marked oth any lipiry or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bertha Whitt John W. Boggs 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 995 Point Pleasant Road, Glen Burnie, Maryland 21060 Elmer H. Plumhoff (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Cedar H111 Cemetery 02-07-09 Brooklyn Park, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McCully—Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 21. Signature of Funeral Service License 23a Port 1. Enter the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) 1UN9 cance **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: A 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed Yes 2 No NA 1 □ Yes 1 ☐ Yes 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No reral Director: / 2 Accident investigation 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 30. Name m who completed cause of death (Item 23a) (Type, Print) HONGAM 3001

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month John Blair Righter February 2009 4:00 A /Medical Sr4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 NC 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1 №M 2 ☐ F Hours Min 52 Director 218-64-3434 04/04/1956 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mertial Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ury or other thaumatic event, Ite M. dical Evanither must be neathed at the content of the property of the property. 10a. State 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shov Examiner must be notified at Director 1 ☐ Yes 2 ☐ No MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21707 784 Wembly Dr. Apt. USA Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Race - American Indian, Black, White, etc. 1 □Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Grocery Store Elementary/Secondary (0-12) College (1-4or 5+) Baker 1.2 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unk. Righter Dorothy Freez ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Blair Righter, Jr./Son 784 Wembly Drive Apt. F Frederick, MD 21707 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Important: If It any Injury or c 1 ☐ Burial 2 SCremation 3 ☐ Removal from State Feb 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Inc. 2009 Beltsville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Marvland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** THEISE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be executed use as the burial-transi and Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy for Month Year 5 ☐ Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 🗖 No 3 Probably 4 Unknown his certificate has been s I director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 ☐ Yes 1 ☐ Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2√2 No Certification: To 1. Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral Date of Injury 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 2 Accident the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal completely (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

Swami

Dr. #207Frederick. MD 21702

Johnson

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas

Registrar's Signatur

Nathan 198

31. Date filed (Month, Day, Year)
FFR 0 6 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year -35 PM NORBERT 2009 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death HOSPITAL SEASONS HOSPICE @ NORTHWEST RANDALLSTOWN BALTIMORE 6. Sex 1 X M 2 □ F 5. Social Security Number 8. Date of Birth (Month Day, Year) (In yrs, last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Months Days Hours 078-22-4598 78 **GERMANY** Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No BALTIMORE OWINGS MILLS 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 136 DISNEY COURT 21117 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 ∐Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ANALYST **HEALTHCARE** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **ROTTER** SIMON BERTHA MELLER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LYNDA ROTTER / WIFE 136 DISNEY COURT, OWINGS MILLS, MD 20b. Place of Disposition *(Name of* MICRO^{PTY} KODES H^rother place) BETH ISRAEL CONG. 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 02/05/2009 22. Name and Address of Facility 21. Signature of Funeral Service Licenses SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially not conuntone, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 🗆 No 26. Place of Death (Check only one) Hospital: Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \times Other (Specify) HOSPICE 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28d. Describe how injury occurred

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

by Funeral

Completed

Be

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its Madical Evaninar must be notified at once.

Baltimore, Maryland 21215-0036

or Attending Physician: The law requires that the death certificate be executed ing physician ar attending p use by the a signed by t r this certificate has been s ral director, page 2 should

Division of Vital Records, P.O. Box 68760,

Examine Be Medical Certification: To

Completed by Physician/Medical

After 124 hours after death. e Funeral Director: A letely filled in by the fu death. within 24 hor To the Fune completely fi

Hospital

25. Was case referred to medical examiner? 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Limited Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

29b. Signature and title of certifier

29c. License numbe

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Registrar's Signature

and manner stated.

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Q2 Day **Physician** 2009 10: 45 AM Dolores Schultheis 04 Α. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL JAMARITAN BALTIMORE 8. Date of Birth (Month, Day, Year)
OCT 26, 19 If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Months Days 1 □ M 2 👿 F Hours 196-28-9240 73 Director 1935 Pennsylvania Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County show 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at MD N/A Baltimore Director 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 403 Calvin Avenue 21218 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married $\mathcal{CH}\,\mathcal{U}\,\mathcal{LTHE}/\mathcal{S}$ \mathcal{D}_{κ} nore, Maryland 21215-0036 1 ☐ Yes 2 👿 No ģ Specify: 3 ☑ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Secretary Banking or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unk. Be11 Unk. 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health a Important: If item 27 is any Injury or other trau 8715 Littlewood Road Parkville, Maryland Scott R. Schultheis, son 21234 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 02/06/09 Baltimore, MD 21. Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of MD, Inc, 299 Frederick Road Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASPIRATION Physician Well MONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): HEART FAILURE Examiner Congestive

Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine RENAL DISEASE ON HEMODIALISE death certificate be executed burial-transit ND-STAPE and Due to (or as a consequence of): P.O. Box 68760, signed by the attending physician abe detached for use as the burial PERTENSION PULMONARY Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed been ANEMIA 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed 1 Yes 2 No this certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient ဥ 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After (Month, Day Year) 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attenct within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month BSTER IRWIN 301AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examine 4c. County of Death REHABILITATION EXTENDED BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Month Days | Hours | Min. | 3-20-1955 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 214-64-8276 Director MD Usual Residence of Decedent 10a. State 10b. County Department of Health and Mental Hygiene. Incurs aries used to Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits Director 1 Ves 2 □ No M n/a **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2316 N. Rosedale Street 21216 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 2 Yes 2 1973-76
If Yes, Give 1973-76
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: African-American \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11th Switchboard Operator Homeless Agency 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Dorsey Smith Mary Griffin ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jay Johnson/Friend <u> 103 Westowne Road, Baltimore, MD 21229</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Veterans 2-12-09 4 Donation 5 Dother (Specify) Ovings Mills, MD e of Funeral Service Licensee 22. Name and Address of Facility Lie Funeral Hime F.A. of Faito. Co. 9200 Liberty Road, Randallstown, MD 21133 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of). physician and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending pl IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an COLOSTOMY this certificate 1 □Yes 2 No 2 🗆 No 1 🗆 Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4X Nursing Home 1 ☐ Yes 2 📉 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 🗆 No 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 124 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) To the I within 2 To the I 29b. Signature and title of certifier ed cause of death (Item 23a) (Type, Print)

MI MN 3900 COCH RANCON BLVD BALTIMARE 212 Registrar

			State of Maryland / Department State of Maryland / Department Certificate		ental Hygiei	711114	03450
	Dhysia	ion	Decedent's Name (First, Middle, Last)		2. Date of Death	110,2	3. Time of Death
	Physic /Medi		Donald Gregory Stelmach		Month February	Day Year 2009	9:15A M
	Exami	ner	4a. Facility Name (If not institution, give street and number) 4b. City, To	own, or Location of Death		4c. County of Death	
	F	_	Stella Maris Hospice 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1	Timonium Year If Under 24 Hrs.	8. Date of Birth	Baltimore	
- 1	Funeral Director		16 M 2□ F Yrs. Months	Days Hours Min.	(Month, Day, Yea	ar) Count	ace (State or Foreign ry)
-	70		Usual Residence of Decedent		12/12/19	956 LMD	
	arylar show	=	10a. State 10b. County 10c. City, Town or Location			10	d. Inside City Limits
	the M	Director	MD Baltimore Essex 10e. Street and Number 10f. Zin C				1 □Yes 2 No
	with y		100.00		10g.	Citizen of What Count	ry?
	death ms 23	Funeral	80 Stemmers Run Rd. 212 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent		cify Yes or No-	SA 14. Race - America	n Indian
E (9	after o	Ē	1 Never Married 2 K Married 1 K Yes 2 □ No .	nt of Hispanic Origin? (Spe y Cuban, Mexican, Puerto F	Rican, etc.)	Black, White, et	
a 3	ours rral",	d b	3 ☐ Widowed 4 ☐ Divorced If Yes, Give 1 ☐ Yes 2	No Specify:		Specify: Whit	0
9:15 a.1	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Event har it ust by notified at	Completed by	15. Decedent's Education 16a. Decedent's Usual (Specify only highest grade completed) (Give kind of work	Occupation done during most of workin retired)	g 16b.	Kind of Business/Indu	
9	filed withir Hygiene. ther than	Ĕ	Elementary/Secondary (0-12) College (1-4or 5+)	retired)	Re	esidental	
	filed Hygi other ent, I	Be Co	12 Carpenter 17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maid	en Surname)	
2009	wuld be Mental arked o	To B	Joseph Stelmack			on Carriamo)	
, [permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evancian to use be notified at once.	-		Viola Ma Street and Number or Rura		y or Town, State, Zip (Code)
7 4 ½	1 and 2 s Health a em 27 is			shire Rd. Dur		21224	,
FEBRUARY Baltimore.	Pages 1 nent of H int: If iter		20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name cemetery, crematory or other	of Da er place)	ate 20c.	Location - City or Tow	n, State
ii Ku	: Pag tmen tant: jury		4 □ Donation 5 □ Other (Specify) Chesapeake Cre		Feb 6 2009 Be	eltsville, M	farvland
FEBRUARY Baltimore.	permit. Page Department Important: If any injury o		21. Signature of Funeral Service Licensee Wolfu(2) 22. Name and	Address of Facility			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode	on and Funeral		ives timore, Mar	/land
			shock, or heart failure. List only one cause on each line.	of dying, such as cardiac or	respiratory arrest,		Approximate nterval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) a. END STAGE LIVER DISEASE Due to (or as a consequence of):				
	Examiner	ш					
	Div #	Je.	Sequentially list conditions, if any leading to in modat. Cause First Underlying.				
	ocuted Ind A transit	Examiner	The sequentially list conditions, if the sequence of the seque				
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-	certi nding se a		IF FEMALE: 23b. Was decement program: 23c. If yes, outcome of pregnancy				
Box	that the death ed by the atter detached for u	Physician/Me	in the past 12 months?			23d. Date of delivery Month D	ay Year
H 0	e law requires that the d has been signed by the e 2 should be detached	nysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 5 ☐ Other (spec	ny)			
STELMACH ecords, P.	s that gned b	by Pi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	se given in Part I.	23e. Did tobacco	use contribute to the	cause of death?
STELMA ecords,	requires een sign nould be				1 ☐ Yes	2 □ No 3 X) Probab	oly 4 □ Unknown
ST	law re as be 2 sho	Completed			24a. Was an	24b. Were autops	y findings available
9 =	The ate h	e e			autopsy performed?	death?	pletion of cause of
DONALD of Vital F	ician; sertific	Be (25. Was case referred to medical examiner?	26. Place of Death		1 1 1 1 2	
9	Physical this call direct	2	1 ☐ Yes 2 📉 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA		e 5 Residence	6X Other (Specify)	HOSPICE
	ding h. After funer	tion		vvork?	ld. Describe how inju	ury occurred	
Division	Atten deat ctor: y the	fical	2 Accident investigation M 3 Suicide 6 Could not be 28e. Place of Injury - At home farm street factors of	1 ☐ Yes 2 ☐ No	If Location (Ctures		
<u>S</u>	al or / s after I Dire	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, of building, etc. (Specify)	120	City or Town, Sta	and Number or Rural F te)	foute Number,
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page.		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the control of the contr	the time, date and place, ar	nd due to the cause((s) and manner as stat	ed.
	the He lin 24 he Ft	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in X Nurse Practitatorer stated.	my opinion, death occurred	d at the time, date ar	nd place, and due to th	e cause(s)
_	North To 1	Σ	29b. Signature and title of certifier 29c. Li	cense number	29d. D	ate signed (Month, Da	y, Year)
	1.1		* GENESLANT R	149792		2/4/2009	
	10+1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			1 11 1	
	Sta	to	JACKIE JONES, CRNP 2300 DULANEY VALLEY RD 31. Date filed (Monif, 'Day, 'Year) 32. Registrar's Signature	. TIMONIUM,	MD 21093		
	Registra		FEB 0 6 2009 Snown S. Sarks				

DHMH 17 Rev 1/2001

DONALD STELMACH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amedin 20b-c, per FH g888 2/13/09 11
State of Maryland / Department of Health and Mental Hygiene Reg. No 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** Smith Leon 0.130 2009 9:00a. Charles /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Sinai Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08 17 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1√2 M 2□ F 36 NC Director 244-52-4314 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28af show any Injury or other traumatic event, the Medical Examiliar insist but without at 1 Yes 2 □ No Director Baltimore MD NA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21215 U.S.A. 5709 Highgate Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 TYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) Public Schools Educator 12th grade 6yr 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Smith ပ Sarah Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5709 Highgate Drive, Baltimore, Md 21215 Edward Smith-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Ukn 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet. 2/11/2009 Owings Mills, MD 22. Name and Address of Facility March F/H West of funeral Service Licenses 21/Signatu 4300 Wabash Ave, Baltimore, Md 21215 3a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, strock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYOCARMAL INFARCTION **Physician** MINIUTES /Medical Due to (or as a consequence of): Examiner BIABETES MELLITUS Sacuentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) OBESITY EARS be executed and Due to (or as a consequence of) burial Box 68760, attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 9 CHRONIC RENAL IMAIR-HYPERTENSION 1 Yes 2 No 3 Probably 4 Nnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No MENT 24a. Was an autopsy certificate 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \(\triangle \text{ Nursing Home} \) 5 \(\triangle \text{ Residence} \) 6 \(\triangle \text{Other} \(\text{(Specify)} \) 1 Yes 2 No 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After ti 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the I within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 121 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4120 PATTERSON AVENUE, BALTIMORE, MD21215 POPESCU DRAGOS MD

Registrar

State

31. Date filed (Month, Day, Year)

FEB 0 6 2009

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 01 **Physician** A^M 2009 Alphonso M. Stanley 1008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Montgomery

9. Birthplace (State or Foreign Country) Bethesda If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Social Security Number 6. Sex **Funeral** Days Months 1**X** M 2□ F 87 Director 067-01-0645 09-15-1921 NY Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County show item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, the "healest Experience reast by retified at 1X Yes 2 □ No Director MD Montgomery Bethesda 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 20814 USA 5721 Grosvenor Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1XXX'es 2 ☐ No 14 Race - American Indian 11. Marital Status Black, White, etc. hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2XXNo Specify: Specify: Black ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) within 72 (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within leath and Mental Hygiene.

m 27 is marked other than College (1-4or 5+) Elementary/Secondary (0-12) 5 Tax consultant years coll Guild Inc./Private 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last)unk Be ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health item 27 i 814 Taylor St. NW Washington DC 20011 David Wigenton/nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages Tent of H permit. Pages Department of Important: If it any Injury or o once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) National Cem. 2/11/2009 Triangle, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall's Funeral Home 4217 9th St NW Washington DC 20011 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a conseque Examiner P.O. Box 68760, The law requires that the death certificate be executed burial-transi and resulting in death) Last Due to (or as a consequence o anding physician use as the buria Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a d be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown s peen s 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? certificate has I 2 No 1 Yes 2 1 ☐ Yes Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 2 ER/Outpatient 3 DOA 1 ☐ Yes 1 Inpatient this Certification: To 28a. Date of Injury (Month, Day, Year) funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After Division 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No death. al or Attendi s after death. I Director: // 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide filled in by determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral I Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year. 06 2009

30. Name and address of person

29b. Signature and title

32. Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

1

D0057574

Bethesda, MD 20814

8600 Old Georgetown Rd

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible. amend Items I Ua-c, e, f per inf g888 2-24-09 vt State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 01 Day 30 **Physician** 2009 07:30 p^{M} Catherine C. Solich /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Catonsville Baltimore Frederick Villa Nursing Home If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** Days 04/04/1915 Hours 1 □ M 2 🕱 F Illinois 93 472-03-0185 Director Usual Residence of Decedent 10c. City, Town or Location
Severn permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Ilmportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any lijury or other traumatic event, the Medical Examiner must he marifical and once. Anne Arundel 10d. Inside City Limits 10a. State 1 ☐ Yes 2 X No Director Johnstown 1 4 1 Cambria 10f. Zip Code **21144–2218** 10g. Citizen of What Country? 8123 Spaulding Circle 84 Beatrice Avenue U.S.A. Funeral 14. Race - American Indian, . Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No à Specify: 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Povacic Stephen Piskurich ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8123 Spaulding Circle, Severn, MD 21144 Marian Krebs, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Ma Burial 2 ☐ Cremation 3 □Removal from State 02/07/2009 Grandview Cemetery Johnstown, Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck. Inc. llegandus 5305 Harford Road, Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 morths? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 4 Nunknown 1 ☐ Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' certificate I 2 1□ Yes Hospital or Attending Physician: director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Hursing Home 5 Residence 6 Other (Specify) 1 Yes 2 100 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient After this funeral 27. Manner of Death 1 Matural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c, License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie address of person who completed cause of death (Item 23a) (Type, Print) D Rd. Cafazville 31. Date filed (Month, Day, Year) 1009 32. Registrar's Signature State 06

DHMH 17 Rev 1/2001

Registrar

FEB

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1 1 9 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 0445 PM Januar Smetona 31 2009 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death N/A Medical Center Baltimore Bayview If Under 1 Year | if Under 24 Hrs. Date of Birth (Month, Day, 20, 1929 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Months Hours Min. Maryland 79 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No N/A Baltimore City 10f. Zip Code 10g. Citizen of What Country? 21222 6726 Roberts Avenue United States 12. Was Decedent Ever in U.S. Armed Forces? 1/ENYes 2 □ No if Yes, Give Year or Dates: Kore. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White Korean 3¥Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Steel Industry Elementary/Secondary (0-12) College (1-4or 5+) Welding Inspector Shipyard 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Annie Yunghandel Frank Smetona 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Michael Smetona (Son) 21013 2828 Forest Glen Drive Baldwin, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Most Holy Redeemer Cem. 2/5/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Inset and Death Immediate Cause (Final disease or condition resulting in death) 0 1 hour

Physician /Medical Examiner

use as

signed by the at d be detached for

page 2 s

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

Division or Vital Records, P.O. Box 68760,

The law requires that the death certificate be executed the burial-transi attending physician and for use as the burial-tran

Be

2

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

in the past 12 months?

_a	Pulmonary Embolism
	Due to (or as a sonsequence of):
t	Deep vein throm bosis Due to (or as a consequence of):
C	Due to (or as a consequence of):
∝ d	hip trocture

2 Fetal death

Theship APPROVED BY MEDICAL EXAMINER 2days 2 days 23d. Date of delivery

Examiner Physician/Medical IF FEMALE: 23b. Was decedent pregnant Part II Other si þ Completed Be 2 Certification:

Medical

1 ☐ Yes 2 ☐ No 9 ☐ Unknown	0	4□Pregnant at time of death 9□Unknown	5 Uther (specify)
l. Other significa	nt conditions cor	ntributing to death but not resulting	in the underlying cause given in Part I.
Dal	HTOI	la continue o	000

23c. If yes, outcome pf pregnancy

Live birth

23e	. Did tobac	co use con	tribute to the cau	ise of death?
	1 🗌 Yes	212 No	3 ☐ Probably	4 ∐Unknow

Month

Day

Year

ypun pillipain.

4a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
T ∨ 2 [a [46] o	1 1 Vac 2 1 Vac

25. Was case referred to medical examiner?
1 √res 2 No 27. Manner of Death 5 Pending investigation 1 ☐ Natural

1 Inpatient 2 □	ER/O
28a. Date of Injury (Month, Day Year)	28b.
Linvary 29,2009	11:

and manner stated.

outpatient 3 DO	Other: 4 Nursing H	orne 5 ☐ Residence 6 ☐ Other (Specify)
Time of Injury	8c. Injury at Work? 1 □ Yes 2 ☑ No	28d. Describe how injury occurred Fell on ice
orm street factors	office	006

3 Ectopic pregnancy

	autopsy performed? 1□ Yes 2 •••••••••••••••••••••••••••••••••••	prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
26. Place of Death (0	Check only one)	

6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, building, etc. (Specify) determined 4 Homicide 29a Certifier

1	Work? 1 ☐ Yes	2 No
acto	ry, office	

	7	011	OIN	ice			
2	8f.	Loca	tion (Stre	et and	Number or	Rural Route N	lumber,
É	-7	26	Robe	State)	Avenue	Bultimore	Maryland
_		, -	1 -0 -110				-166

29b. Signature and title of certifier

2 Accident

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Maryland

MD

29c. License number Res-000 January 31, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940 Eastern Avenue Baltimore. James Johnston M.D 31. Date filed (Month, Day; Year) 32. Registrar's Signature

State Registrar



home

DHMH 17 Rev 1/2001

			For State Registrar		ai yiai i		tificate of D		,	Reg. No	0000	03455
	Physici /Medic		1. Decedent's Name (First, Middle Emanuel			3h	emin		2. Date of De Month	ry ox	8_200	3. Time of Death
	Examir	ner	4a. Facility Name (If not institution The Johns Hopkins				4b. City, Town, or Baltimore			J 4c.	. County of Deat	h
	Funeral Director		5. Social Security Number 074-28-5250		ge (In yrs. la 78	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Nov 2	rth a <i>y</i> , Yea <i>r</i>)	Co	hplace (State or Foreign untry) V York, NY
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
	Mary a-f sh ified a	ctor	FL Palm F	Beach	Вос	a Rato	n					1 Yes 2 □ No
	vith the	Director	10e. Street and Number	n1 1/			10f. Zip-Code				izen of What Co	untry?
	ms 23	Funeral	800 South Ocear	12. Was Decedent	Ever in U.S	i. 13. \	33432 Nas Decedent of His f Yes, specify Cubar	spanic Origin? (S	pecify Yes or No	USA	14. Race - Ame	rican Indian,
21215-0036	be filed within 72 hours after death with the Maryland ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ★ Yes 2 □ If Yes, Give Year or Dates:	№ 195 19	2-	f Yes, specify Cubar I ☐ Yes 2 🙀 No	n, Mexican, Puerto Specify:	o Rican, etc.)		Black, White Specify:	e, etc.
15-0	n 72 h "natur edical	Completed	(Specify only highe	t's Education st grade completed)		(Give	dent's Usual Occupa kind of work done d DO NOT use retired)	luring most of wor	king	16b. K	ind of Business/	Industry
212	l withir jiene. r than	ошо	Elementary/Secondary (0-12)	College (1-4 or 9	5+)		Employed			Нс	orticult	ure
	be filed tal Hygi d other event, th	Be C	17. Father's Name (First, Middle,	Last)				18. Mother's Nar			Surname)	
Maryland	should be and Mental marked o	욘	William Shemin 19a. Informant's Name/Relations	hin (Type Print)		10h Mailin	ig Address (Street a		Schiffe		r Town State 7	(in Code)
			Rhoda Shemin -				South Oce					FL 33432
Baltimore,	of Health of Health if item 27 i		20a. Method of Disposition 1 本Burial 2 ☐ Cremation		20b. Pl		sition (Name of natory or other place		Date		ocation - City or	
Ë,	Page tment tant: It jury o		4 Donation 5 Other (S	pecify)		mple S	holom Cem	1. 1/30			enwich,	CT
Ball	permit. Pages 1 and 2 Department of Health s Important: If item 27 is any injury or other tra		21. Signature of Funeral Service I	endle			Name and Addres Fred D. 267 Gree	enwich Av	zenue (Freer	Home	T
1	Physician /	(23a Part 1 Enter the disease, or shock or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on each ling.	e.)yelo	genous	,	c or respiratory a			Approximate Interval Between Onset and Death
	Examiner	÷	Sequentially list conditions,	Due to (or as	a consequ	eng oi).	3					
\x	ed rsit	Examiner	il any, leading to in rediate cause. Enter Underlying Cause (Disease or injury	July to (or as	# CONSEQU	erioe ct):						
10	tificate be executed g physician and as the burial-transit		that initiated events resulting in death) Last	c. Due to (or as	a conseque	ence of):						
68760,	ite be i lysiciai he bur	Medical		d								
Box		Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 2 No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant al	2 🗌 Fetal	death 3 [Ectopic pregnancy Other (specify)				23d. Date of deli Month	ivery Day Year
ds, P.O.	signed by	þ	Part II. Other significant condition	ins contributing to death b	out not resu	lting in the u	nderlying cause give	en in Part I.	23e. Did 1			the cause of death?
Records,	has ge 2	Completed				•			24a. Was autor perfo		prior to death?	topsy findings available completion of cause of
<u>lta</u>		Be	25. Was case referred to medical examiner?	Hospital: V.				26. Place of Deat	th (Check only o			
6	Phys this ral d	6	1 ☐ Yes 2 No 27. Manger of Death	28a. Date of Inju		R/Outpatient 28b. Time of	28c. Injury	at Nuising Pic	ome 5 Residence Residence 28d. Describe		6 Other (Spec	ify)
Ö	ath. : After re fune	ation	1 Natural 5 Pending	(Month, Day		Injury	Work?	es 2 🗌 No			, 0004.700	
Division of Vital	al or Attens s after deat al Director: ed in by the	Certification:	3 Suicide 6 Could in determ	ned building, etc	c. (Specify)				City or Tov	vn, State)		ral Route Number,
)	To the Hospital or Attend within 24 hours after death To the Funeral Director: . completely filled in by the	edical	one) 2 Medical	g Physician: To the best of Examiner: On the basis of and manner sta	f examination	ledge, death on and/or inv	estigation, in my op	inion, death occu	, and due to the irred at the time,	cause(s) , date and	and manner as d place, and due	stated. to the cause(s)
	To the I within 2 To the I comple	Σ	29b. Signature and title of certifier	Davison, 1	MD		RES-			29d. Dat	e signed (Month	Day, Year)
	1		30. Name and address of person			23a) (Tyne I				anu	<u>ary x c</u>	$, \alpha u u $
	1		ASHWINI DAVISO	N				600	North Wo	lfe S	t, Baltimo	re, MD, 21287
	Sta Registr	te ar	FEB 0 6 2005	32. Registra	ır's Signatu	parke	1					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 03456 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2 **Physician** Zelma S. Saunders 5:44 a M 4 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bayview Hospital Baltimore

Mer 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11-2-1938 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 😿 F Director 70 212-36-6661 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at MD 1 TyYes 2 □ No Director N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1700 Edmondson Funeral 12. Was Decedent Ever in U.S. Armed Forces? 21229 USA 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes A ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No þ Specify: 3€Widowed 4 □ Divorced Black Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) State of MD 12th grade Claim Adjuster is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Sewell ဥ Josphine Moore 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau once. Vernon Brown-Son Eastbury Avenue Apt H Balto, MD 21206 20b. Place of Disposition (Name of cemeterv. crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) King Memorial Pk 2-7-2009 Randallstown, MD 22. Name and Address of Facility March East F/H 21. Signature of Funeral Service Licensee 1101 E. North Avenue Balto, MD 2102 ending 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SWI **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Onknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t lirector, page 2 s autopsy performe 2 No 1 ☐ Yes Yes To the Hospital or Attending Physiclan: the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No P 1 Inpatient 2 ER/Outpatient 3□ DOA After this 27. Manuar of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No after death i Director: A d in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide filled 1 24 hours 2 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou To the Fune completely fil 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

DHMH 17 Rev 1/2001

State

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

FEB 0 6 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Paint) Woodsfood. MD 21234

881

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 05:47 PM 2009 tebruary /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** sorla N/A 8. Date of Birth (Month, Day, March 29, 9. Birthplace (State or Foreign Country)
Maryland 7. Age (In yrs. last birthday) If Under 24 Hrs Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 KM 2 F 212-03-8927 92 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its Medical Examination to other profiled at once. N/A Baltimore 1 Yes 2 No Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21230 1743 Covington Street U.S.A. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Printing Company 8 0 Printer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unkown Otto Unkown ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, Maryland 21230 Donald Jackson (friend) 1470 Reynolds Street, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ■ Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery 02-05-09 Brooklyn Park, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility McCully Polyniak Funeral Home P.A. 130 East Fort Avenue, Baltimore, Maryland 21230 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ulmonary INKNOWN /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) cate has been signed by the a page 2 should be detached it 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by leeding 3 Probably 4 Number 1 □ Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 No 24a, Was an certificate eumonta 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 ☐Yes 2 ☐ No veral Director: A investigation within 24 hours after death.

To the Funeral Director: A 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State

State Registrar tanover

South

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Oba

6

31. Date filed (Month, Day, Year)

			For State	State of Ma	iryland			nt of H e <i>te of L</i>		Mer			20	0.0	0.5	1.50
			Registrar 1. Decedent's Name (First, Middle, Las	st)		061	tilloc	ile Of L	Jeani	2.	Date of Dea			n a	3. Tim	e of Death
	Physicia		MA	ARGARET MARY STEARNS JAN 31 2009								Year 109	9:	40 A ^M		
-	/Medic Examin		4a. Facility Name (If not institution, give								of Death					
أنور			NATIONAL NAVAI			17.1.1		HESDA					MONTO			
	Funeral		5. Social Security Number 6. S	ex 7.Age □M2[x]F	(In yrs. las	t birthday) . Yrs.	Month	er 1 Year s Days	If Under 24 Hrs Hours Min		Date of Birt Month, Da	h y, Year)		9. Birthp Coun	lace (State)	ate or Foreign
	Director		218-66-2693 Usual Residence of Decedent		93					Ma	y 6, 19	113		Washir	ig com	, 10
	yland now		10a. State 10b. County		10c. City,	Town or Loc	cation							10	Od. Insid	e City Limits
	Mar Ma-fsl	ctor	Maryland Montgome	ry	Bethe	sda									1 🗆	Yes 2∏XNo
	or 28	Director	10e. Street and Number					ip Code			- 1			Vhat Coun		
	ath w		5829 Conway Road	10.11	II O	40.14		0817	i- O-i-i-0 //	0	-			State		
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, The Medical Examinar must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 □ Yes 2 ☑ N If Yes, Give Year or Dates:		-		ecify Cuba	spanic Origin? (n, Mexican, Puer Specify:	to Rica	n, etc.)		Blac	e - Americ k, White, e : Whi	etc.	η,
2-0	72 hor	eted	15. Decedent's Ed (Specify only highest gra	ucation de completed)		16a. Deced	lent's Us	sual Occupa	ation Jurina most of wa	rkina		16b. Kii	nd of Bu	usiness/Ind	lustry	
21	ithin 7 ne. han "u	Completed	Elementary/Secondary (0-12)	College (1-4or 5-					luring most of wo)	9	į	0				
121	iled w Hygiel Ither ti		12 17. Father's Name (First, Middle, Last)			Homen	iake	r	18. Mother's Na	me (Fi	st Middle		Hot Surnam			
anc	d be fi) Be	Michael S. Roche						Margare				ourran.	,		
Σ	shoull nd Mo mark	ဠ	19a. Informant's Name/Relationship (Type. Print)		19b. Mailin	g Addre	ss (Street a	and Number or R				r Town,	State, Zip	Code)	
ž	and 2 valth a valth a valth a valth a valth a valth a		Michele A. Munoz/	Daughter		9603	Hil	lridg	e Drive,	Ke	nsing	ton,	Ma	rylan	d 20)895
ore	of He of He fiten		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Romoval from State	20b. Plac cem	e of Dispos etery, crem	sition (Natory of	ame of other place	e) Marc	Date h 6		20c. Lo	cation -	City or To	wn, Stat	е
Ē	Pag ment tant: I		4 ☐ Donation 5 ☐ Other (Specify	/)	Arlin	gton Na			etery 200	9				on, V		
Baltimore, Maryland 21215-0036	permit Depari Impor any in		21. Signature of Funeral Service Licen Butterry Blue	it	M0154	8 Ro 75	, Name bert 57 Wi	and Addres A. Pum sconsi	s of Facility phrey Func n Avenue, I	eral Beth	Home/E	Bethes Maryl	sda- (and 2	Chevy (20814	Chase	e, Inc.
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused one cause on each line	the death. e.	Do not ente	er the m	ode of dying	g, such as cardia	c or re	spiratory ar	rest,				mate Between and Death
*	Physician		Immediate Cause (Final disease or condition resulting in death)	и	NEUMON											
T	/Medical Examiner		Toodhing in addain,	Due to (or as a	consequer	nce of):										
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b Due to (or as a	consequer	nce of):										
3	outed ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C												
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68760,0	ificate be executed g physician and as the burial-transit	edical	•	d												
			IF FEMALE:	23c. If yes, outcome of	of pregnance	v										
Вох	atten for us	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live birth 3	2 🗀 Fetal de	eath 3□		pregnancy	,			2	3d. Dat Mo	e of delive nth	ry Day	Year
o.	the d	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown		0	, 0 11101 (opoony/								
ر, ص	The law requires that the death cer ate has been signed by the attendin page 2 should be detached for use	by Pi	Part II. Other significant conditions of	ontributing to death bu	t not resultir	ng in the un	derlying	cause give	en in Part I.		23e. Did to	bacco u	se contr	ribute to th	e cause	of death?
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of o	Physical this cal dire	၉	1 ☐ Yes 2 No		nt 2 EF		t 3□		4 LI Nursing I						"	
uc.	ding I	ion	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day		Bb. Time of Injury	М	28c. Injury Work 1 □ \	/aι ? /es 2∐No	280.	Describe h	iow injury	occurre	ea		
Division of Vital Records	or Attending Physician: after death. Director: After this certifici	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined		ry - At home . (Specify)	e, farm, stre		l		28f. Location (Street and Number or Rural Route Number, City or Town, State)			Number,			
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the best on niner: On the basis of and manner star	examination	edge, death n and/or inv	occurre	ed at the timon, in my op	ne, date and place pinion, death occ	e, and urred a	due to the	cause(s) date and	and ma	anner as st and due to	tated. the cau	se(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	/	2,		2	9c. License	number		:	C 1	_	d (Month, L	Day, Yea	r)
			Vennet	16/	up (MP		01010)50097 (VA)		i-ek)	2	20	09
	On		30. Name and address of person who	completed cause of de	eath (Item 2	3a) (Type, F	Print)				NAVA				NTE	}
	+		KENNETH G. PUCH	CDR	USN r's Signatur	3			BETHE	SDA	MD 2	0889	-560	00		
	Sta	le	31. Date filed (Month, Day, Near)	202. Registra	s organitum	bout	A PAR									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10:15 P ^M SYLVIA SHAPIRO JANUARY 31 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11209 FIVE SPRINGS ROAD LUTHERVILLE BALTIMORE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 X F Months Days Hours 216-30-0977 75 10/28/1933 **Director** MD Usual Residence of Decedent iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. It Item 27 is marked other than "natural", or items 23a or 28a-f show or other thatmatic event, the Medical Eventual bo nutting at 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☐ Yes 2 No Director MD BALTIMORE LUTHERVILLE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 11209 FIVE SPRINGS ROAD 21093 <u>USA</u> by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No WHITE If Yes, Give Year or Dates: Specify. Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Ly Important: If Item 27 Is marked oth any lighty or other traumatic event once. Be ပ ISIDORE SCHULMAN FAYE KLASSMAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALVIN Y SHAPIRO / HUSBAND 11209 FIVE SPRINGS ROAD, LUTHERVILLE, MD 21093 20b. Place of Disposition (Name of ARL TNGTON THE CHI 20 K Place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 02/04/2009 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) AMUNO_CONG. SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 21. Signature of Funeral Sen 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** disease or condition resulting in death) my /Medical Due to (or as a consequence of): Examiner Ken Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of the Exami and Due to (or as a consequence of): Box 68760, attending physician for use as the buria certificate be Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) signed by the a be detached f 2 No o 9 Unknown 9 Unknown ₫. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 ☐ Yes ial or Attending Physician: "s after death. I Director: After this certification by the funeral director, p 25. Was case referred edical examiner? Be 26. Place of Death (Check only one) Other: 4 \subseteq Nursing Home 5 \textcap{\infty} Residence 6 \subseteq Other (Specify) Hospital 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral D Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29d. Date signed (Morith, Day, Year) 29b. Signature and title of certifier 8029

10V

State Registrar

DHMH 17 Rev 1/2001

gistrar

31. Date filed (Monthy Day, -Year) --- 32

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

lis

Registrar's Signature

- 90

		•	For State of Maryland / Dep.	rtificate of Death	Reg	2009 03460
	Physici	an	1. Decedent's Name (First, Middle, Last) SHARON D S	TERN	2. Date of Death	3. Time of Death 8:55 P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat		4c. County of Death
- 4			6508 RANGING HILLS GATE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	COLUMBIA If Under 1 Year If Under 24 Hrs	8 Date of Birth	HOWARD
	Funeral Director		0. Sex 1 ⊆ M 2 M F 59 Yrs. Usual Residence of Decedent	Months Days Hours Min.		9. Birthplace (State or Foreign Country) NY
	yland how		10a. State 10b. County 10c. City, Town or Let	ocation		10d. Inside City Limits
	Ba-fs	ector	MD HOWARD COLUMB			1 □Yes 2 NNo
	3a or 2	i Dir	10e. Street and Number 6508 RANGING HILLS GATE	10f. Zip Code 21044	100	g. Citizen of What Country? USA
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Its Modinal Examinar must be realthed at once.	Completed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 W Married 1 □ Yes 2 W No	Was Decedent of Hispanic Origin? (§ If Yes, specify Cuban, Mexican, Puer 1 □Yes 2 ሺ No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE
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pd	al Hyg I other went,	Be C	17. Father's Name (First, Middle, Last)		me (First, Middle, Ma	•
ryla	d Ment d Ment narked natic e	٦	MILTON DREXLER 19a. Informant's Name/Relationship (Type. Print) 19b. Maili	MOLL ng Address (Street and Number or R		RYSHPAN Situ or Town State Vin Code)
Ma	alth an 27 is 1		,	RANGING HILLS GA	•	
Baltimore, Maryland 21215-0036	Pages 1 a ment of He ant: If item ury or othe		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 20b. Place of Disposition Collume IA N	osition (Name of matory or other place) 1EMORIAL PARK 02/0	5/2009	COLUMBIA, MD
Bait	permit. Depart Import any Inj once.		21. Signature of Funeral Service Licensee	2. Name and Address of Facility 8900 REISTERSTOW	SOL LEVIN N ROAD -	SON & BROS., INC. PIKESVILLE, MD 21208
	o		23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.			t, Approximate Interval Between Onset and Death
-	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	BRIDET CONCE	しへ:	
1	Examiner					
	ted sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury			
oʻ	execu an and rial-tra	Exar	that initiated events ' c. Due to (or as a consequence of):			
68760,	ficate be executed physician and s the burial-transit	dical	d			
Вох 6	th certification is use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3	☐ Ectopic pregnancy		23d. Date of delivery Month Day Year
P.O.	the dea y the a ched fo	ıysici	1 □ Yes 2 No 9 □ Unknown 9 □ Unknown 5 [Other (specify)		Month Bay Foat
ds, P.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ρ	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.		cco use contribute to the cause of death? 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
Records,	w requ	Completed			24a. Was an	24b. Were autopsy findings available
8	hysician: The la his certificate ha: Il director, page 2	Somp			autopsy performe 1 □ Yes 2 ∑	prior to completion of cause of death? No 1 □ Yes 2 □ No
Z Z Z	sician: certific rector,	Be	25. Was case referred to medical examiner?	Othor	ath (Check only one)	
o	g Physer this leral di	n: 70	27. Manner of Death 28a. Date of Injury 29b. Time of	III 3 DOA 4 I Nursing F	dome 5 🔊 Residence 28d. Describe how	ce 6 Other (Specify) injury occurred
sior	tendin eath. tor: Aff	catio	2 Accident investigation	M 1 □Yes 2 □No		
Division of Vital	tal or Att rs after d al Direct ed in by	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, sti	eet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
1	Hospi 24 hour Funer tely fill	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated	h occurred at the time, date and place avestigation, in my opinion, death occ	e, and due to the cau urred at the time, date	use(s) and manner as stated. e and place, and due to the cause(s)
	vithin 3	Mec	one) and manner stated. 29b. Signature and title of certifier	29c. License number	29d	I. Date signed (Month, Day, Year)
			An (my ns.	10018320		214/09.
	6			Print) Print) Print) No. hor	みといいしょ	MJ 21093.
	Sta Registr		31. Date filed (Month, Day, Year) 32 Registrar's Signature	W. 1		

DHMH 17 Rev 1/2001

Registrar
DHMH 17 Rev 1/2001

State

JACKIE JONES.

FER 0 6 2009

31. Date filed (Month, Day, Year)

FEBRUARY

TEUTEBERG

JAMES

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

person who completed cause of death (Item 23a) (Type, Print)

CRNP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 03462 Certificate of Death Decedent's Name (First, Mildle, Last) 2. Date of Death Day **Physician** I hompson 2007 1205AM Ebruan /Medical facility Name (I) not institution, give street and numbe Examiner 4c. County of Death Age (In yrs. last birthday) Deasons timore If Under 1 Year Social Security Number **Funeral** 1**X**M 2□ F Months Days Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, "w. Medical Examinar wust be notified at once. 1 Nes 2 No Funeral Director timore 10e. Street and Number 10g. Citizen of What Country? Apt. vania 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 No þ Specify: Blac 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry during most of working Elementary/Secondary (0-12) College (1-4or 5+) UNK ason Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Hessi e 19a. Informant ame/Relati nship (Type. Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) olumbia, MD 21045 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatury of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician UNG disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): To the Hospital or Attending Physiclan: The law requires that the death certificate be executed burial-trans attending physician and for use as the hurial-tran-Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate 2 No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 6 Other (Speci Hospital: Other: 4 Nursing Home 5 Residence 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29d. Date signed (Month, Day, Year)

Registrar

State

boran

31. Date filed (Month, Day,

2835

Smith Avenue Sufe 203

who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

00

Amend #8 per FH g888 2/27/09 TT
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Maryla		artment of F			iene	100	031.63	
	E d		1. Decedent's Name (First, Middle, Las	it)				2. Date of Dear		Year	3. Time of Death	
4.	Physici /Medio	al	Earl D Trent	- A A and a support		4. Ch. T		January	_29	2009	7:00A ^M	
1	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death									
	Funeral		Cherry Lane Nursing Home Laure1 5. Social Security Number 229-18-5078 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Annual Months Days Hours Min. (Month, Day, Year) (Month, Day, Year) (Month, Day, Year) VA Prince Georges 9. Birthplace (State or For Country) VA									
	Director		5. Social Security Number 229-18-5078 6. Sex 1 Age (In yrs. last birthday) 90 Yrs. 1 Age (In yrs. last birthday) 1 Age (In y									
	yland yland		10a. State 10b. County	10c. (City, Town or L	ocation				1	0d. Inside City Limits	
	Ba-f si	Director	MD Prince Ge	orges Up	per Mar						1 ☐ Yes 2XCXNo	
	with the or 2	Dire	10e. Street and Number			10f. Zip Code 20774				of What Cour	ntry?	
	ms 23	nera	305 Aden Court 11. Maritat Status	12. Was Decedent Ever in	U.S. 13.	Was Decedent of I	Hispanic Origin? (S	Specify Yes or No-		lace - Americ		
920	be filed within 72 hours elter death with the Maryland ital Hyglene. Id other than "neturel", or items 23a or 28a-f show event, I're Medical Exeminal must be notified at	by Funeral	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 万¥Yes 2 ☐ No If Yes, Give Year or Dates:		tt Yes, specify Cub 1 ☐ Yes 2 🛣 No		to Hican, etc.)		Black, White, cify: Blac		
Maryland 21215-0036	thin 72 ho e. an "netul Medical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	rking		Business/Ind	dustry					
2	filed wi Hygien other th		17. Father's Name (First, Middle, Last)	2 years col	Bric	k Mason	19 Mothodo No	me (First, Middle, I	Priva			
and	Mental harked of	To Be	Edward Trent				Onie Gr		vialdell Sull.	iarrie)		
ary	2 should be and Mental ie marked d eumatic ev	1-	19a. Informant's Name/Retationship (7	Type, Print)	19b. Maili	ing Address (Street		ural Route Number	, City or Tov	vn, State, Zip	Code)	
∑	and 2 lealth m 27 i		Dr. Earl D Trent					Bowie MD				
Baltimore,	permit. Pages 1 and 2 should by Department of Health and Menta Importent: if item 27 ie marked eny injury or other treumatic e <u>once</u> .		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Mentioval Ironi State		osition (Name of matory or other pla	!			$1\mathrm{e}$, V A		
ii.	mit. P partme porten injur;		4 □Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen	1-4		Nat. Ceme 2. Name and Addre		.1/09 :rshall's				
<u>~</u>	Depa Impo eny i		JP marsha	00,				hington				
п			23a. Palt1. Enter the disease, or complete hock, or heart failure. List only	plications that caused the de one cause on each line.	eath. Do not en	ter the mode of dyli	ng, such as cardia	c or respiratory arri	est,		Approximate Interval Between Onset and Death	
ag.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Dementia Due to (or as a cons	equence of):							
-	Examiner		Sequentially list conditions	b								
	S. 77 .02	Examiner	Sequentially list conditions, if any, leading to immediate cause. Line Unit hying Cause (Disease or injury	Due to (or as a cons	equence ot):							
<u>,</u>	be executed ician and burial-transi	Exan	that initiated events resulting in death) Last	c. Due to (or as a cons	equence of):					-		
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39 x	ertifica ding pt	/Med	IF FEMALE:	22a Maria automa of mar								
P.O. Box	at the death certificate be executed by the ettending physician and tached for use as the burial-transit	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1								23d. Date ot delivery Month Day Year	
	The law requires that the site has been signed by the page 2 should be detache	by Ph	Part II. Other significant conditions of	ontributing to death but not r	esulting in the u	ınderlying cause gıv	ven in Part I.	23e. Did tot	oacco use co	ontribute to th	ne cause of death?	
ğ	w require been sig should b	ted t	Pneumonia 1 Yes								ably 4 Unknown	
Records,	has by ye 2 sh	Completed	Sacral decubitus	ulcer				24a. Was a autops perior	y	b. Were auto prior to cor death?	psy findings available mpletion of cause of	
	icien: Th certificete rector, pag		25. Was case reterred to medical				Of Disco of Do	1 ☐ Yes 2	2 DENO	1 Yes	2 No	
⋛	Physicien: The this certificate har at director, page	To Be	examiner? 1 Yes 2 XNo	Hospitat: 1 ☐ Inpatient 2	☐ ER/Outpatie	nt 3 DOA		dome 5 ☐ Reside		Other (Specify	y)	
o no	ding Ph h. After thi funeral		27. Manner of Death 1 ⊠Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wo		28d. Describe ho	w intury occ	curred		
Division of Vital	Atten r deat octor:	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of triury - At	home, tarm, st		Yes 2 □No	28t. Location (St		mber or Rura	I Route Number.	
	rs after el Dire	Cert	4 Homicide determined	building, etc. (Spe	city)			City or Towr	n, State)			
	To the Hospitel within 24 hours a To the Funerel Completely filled	edicai	(Check only 2 Medical Exam	ysician: To the best of my k niner: On the basis of exami and manner stated.	nowledge, deat ination and/or in	th occurred at the til evestigation, in my o	me, date and place opinion, death occ	e, and due to the caurred at the time, d	ause(s) and ate and plac	manner as st e, and due to	ated. the cause(s)	
	With You	Σ	29b. Signature and His ot certifier	I de		29c. Licens	0053235			ned (Month,)	*	
	le		30. Name and address of person who			•	1 100 00	7.07	- 1			
ji.	Sta	į ite	Darryl Hill 31. Date tiled (Month Par Year)	13635 Balti 32. Registrar's St	more Av	enue Laur	rel,MD 20	1/0/				
	Registr		FEB 0 5 2009	Deneur D.	A Cart							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 03464 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** Year 3,508 M 200 /Medical 4a. Facility Name (If not institution give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MORE N/A 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day Ye 06-30-1976 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1 **⊠** M 2 □ F Months Days Min North Carolina 227-19-8886 32 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Maryland Howard Jessun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7502 Gleneagle Drive 20794 U.S.A. Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 M Married 1 ☐Yes 2 ☑No Specify þ Specify. 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Crane Operator Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nathan C. Thornton, Sr. Helen Dail ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5329 Indian Oak Road Mrs. Helen Thornton-Anderson Crewe, Virginia 23930 Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 02/07/2009 4 ☐ Donation 5 ☐ Other (Specify) Merchants Hope Mem. Garden's Hopewell, Virginia 21. Signature of Funeral Service 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, MD 21214 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each live. Approximate Interval Between Onset and Death Immediate Caus (Final **Physician** disease or condition resulting in death) /Medical Due to (onas a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Physician/Medical Examiner ue to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed the burial-transi Due to (or as a consequence of) P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 210No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2-EN0 1 ☐ Yes 2 ☐ No rs after deam, rai Director: After this cerus. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Deeth Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide Hospitai 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely (Check only one) 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20

State Registrar 31. Date filed (Morten, Day,

32.

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 4c. County of Death Town, or Location of Death 4a. Facility Name (If not institution, give street and number) ALTIMORE VII If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 10/17/ Months Days Hours Year. 1**X** M 2 ☐ F 1954 Baltimore, MD 214-64-4985 54 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Baltimore Parkville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 14 Clearlake Court 21234 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Legal Law Clerk 12 18. Mother's Name (First, Middle, Maiden Sumame) UK 17. Father's Name (First, Middle, Last) Josephine Alexander Leonard Urban 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7708 German Hill Rd. Baltimore, MD 21222 William Bacon, Jr./friend 20b. Place of Disposition (Name of Evants) crematory or other place) Chapel – Bel Air 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Forest Hill, MD 02/05/09 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Evans Funeral Chapel & Cremation Se 8800 Harford Rd. Parkville, MD 21234 of Funeral Service License Cremation Services Approximate Interval Between Onset and Death 2. a. Par I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line. I mmediate Cause (Final liseage or condition racing in death) ACUTZ ue to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 10 URS 15UTOPATTH2 Due to (or as a consequence 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy perforn 1 □Yes 2XINo 26. Place of Death (Check only one, Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 XNatural 5 Pending investigation

be executed burial-tran and attending physician for use as the ed by the a detached for signed by t 1 be detach Division of Vital Records, cate has been signated by page 2 should b this certificate

Box 68760.

P.O. |

Physician:

Hospital or Attending Pl 24 hours after death. Funeral Director: After the

To the Hospital or within 24 hours a To the Funeral D

After t

filled in by

completely

Medical

State Registrar

Physician

Examiner

/Medical

Physician /Medical

Examiner

10a. State

Director

Funeral

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Completed

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modeal Eventher must be notified at

Baltimore, Maryland 21215-0036

Exami Physician/Medical \$ Completed funeral director, Be Certification: To the

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner?

28a. Date of Injury (Month, Day, Year)

29a. Certifier

2 Accident

3 Suicide

4 Homicide

6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

(Check only one) 29b. Signature and title of certifier

29c. License number

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 23 EASTERN TKOZV

and manner stated.

31. Date filed (Month, Day, Year 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-00461 State of Maryland / Department of Health and Mental Hygiene Jose Santos Villalta 009 03466 Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day January 16, 2009 0812 hrs Medical Examine Jose Santos Villalta c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Hyattsville 6301 Ager Road If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Foreign E1 Salvador Months Days Hours Min Director 197 2 37 May 641-03-2935 1 X M Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location any. 10b. Count 1 X Yes 2 No 28a-f show Hyattsville items 23a or 28a-f shoust be notified at once, Prince George's MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Ē 20782 Salvador 3408 Toledo Terrace #K6 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11 Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married Married 2 X No Yes or i Specify: White f Yes, Give Year 1 X Yes 2 No specify: salvadoran Divorced Widowed Δ à 16h Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+ Elementary/Secondary (0-12) than North West Electric Laborer other t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) is marked Be Luis Diaz Teresa Villalta 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3408 Toledo Terrace #K6 Hyattsville, MD 20782 nt: If item 27 i r other tranmal Juan G. Villalta (Brother) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 01-24-09 portant: Glenwood Cemetery Washington DC Donation 5 5 22. Name and Address of Facility W. H. Bacon Funeral Home, Inc. anature of Funeral Service Lice 3447 14th St.N.W. Washington DC 20010 used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva the dis Physician Between Onset and failure. List only one cause on ea 'Medical Death Immediate Cause (Final disease intoxication aminer or condition resulting in death) Due to (of as a consequence of) Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last requires that the death certificate be executed 23a,27,28a-f, perME, g888 2/23/09 TT 28f per ME g889 3/3/09 TT Physician/Medical X AMENDED attending physician or use as the burial X UNPENDED Box 68760 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE Day Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Fetal death Live birth past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Ö Yes 2 ✓ No 3 Probably 4 ě Completed Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? The law performed this certificate has Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical Physician: of Vital Be Other₄ Hospital: 1 Residence 6 V Other: Scene Nursing Home 5 Inpatient 2 ER/Outpatient 3 1 V Yes 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury After 27. Manner of Death Hospital or Attending 24 hours after death. Certification: Yes 2 X No Natural Division unk Pending the 1/16/09 Director: Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6301 Agar Rd Ager Rd Hyattsville, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be Suicide house (Specify) 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier January 17, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Margarita Korell MD. 31. Date filed (Month, Day, Year 32. Registrar's Signature State and Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ROBERT VENABLES ,2009 January 29 4:40 p. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 910 01d 0ak Road Baltimore Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1√2 M 2□ F 217-26-5788 Director 91 Nov. 1,1917 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at 1 □Yes 2 No Director Maryland Baltimore Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 910 01d 0ak Road 21212 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. \$ Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) National Claim Manager Insurance years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Venables, Sr. Esther Rider Dougherty 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne V. Downs (daughter) 405 Alder Street Pacific Grove, California 93950 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2-6-09 Park Cemetery: 2-6-09 | Baltimore, Maryland
22. Name and Address of Facility Mitchell-Wiedefeld F.H. Inc. 21. Signature of Funeral Service Licensee 6500 York Road Baltimore, Maryland 21212 renous 23a. Part 1. Ent. r the dis ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lipe. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of). 1C/WOMA Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner ending physician and use as the burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ş 3 ☐ robably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed Division of Vital 1 ☐ Yes 2 ☐ No 1 □ Yes 2 **M**No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to hedical Be 26. Place of Death (Check only one examiner? Hospital: Other: 4 \sum Nursing Home 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 5 Desidence 6 ☐ Other (Specify) funeral 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Detural 5 Pending investigation I Director: A 1 Tes 2 🗆 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical manner stated

State Registrar 29b. Signature and title of

Name and address of

Year)

6

31. Date filed (Month, Day

on who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

29d. Date signed (Month, Day, Year) 212109

09-00825 John Valenta Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

8

ohn Valenta	1- For State	Sta	ate of Maryland		rtment of l tificate of l		a ivientai		Reg. No. 2 1	00 031.6		
Physician/	1. Decedent's N	ame (First, Middle Johr		enta			215.7	2. Date of Dea	ath	3. Time of Death 0600 hrs		
Medical Examine	4a. Facility Nam		. City, Town, or	Location of D	Month January 2	28, 2009 4c. County of Dea						
	Montgomery General Hospital						5		Montgomery			
Funeral Director	5. Social Securit	·	6. Sex 7. Ag	je (In yrs. la 25	st birthday) Yrs.	If Under 1 Year Months Days		Min	16, 1983	Birthplace (State or eign Country) Maryland		
aus	Usual Residence 10a. State	of Decedent 10b. County		10c. City,	Town or Location	n				10d. Inside City Limits		
≥	Marylan	d Montg	gomery		Rockvi	11e				1 Yes 2 X No		
the Maryland as or 28a-f sho tiffed at once.	10e. Street and			<u> </u>		10f. Zip Code			10g. Citizen of What Co	,		
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Statu 1 X Never Ma 3 Widowed	arried 2 Ma	Armed Forces		If Yes	s, specify Cubar Yes $2X$ No	ı, Mexican, Pu	uerto Rican, etc.)	White, etc.			
nours aft			cify only highest grade co		16a. Decedent's	s Usual Occupat			16b. Kind of Busines	s/Industry		
36 nin 72 h than "n dical E	Elementary/S	econdary (0-12)	College (1-4 or	5+)	Ü	ty Offi		,	Hosp	ital		
5-0036 ed within 72 hour lygiene. other than "nature Medical Exan	17. Father's Nar	ne (First, Middle,	Last)			1		Name (First, Middle,				
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re, N l and l Health fitem	20a. Method of		0 🗆 Barrard from 0		Place of Dispositi erematory or other		metery,	Date February	20c. Location - City	or Town, State		
mol Pages nent of ant: Il	1 X Burial 4 Donation	5 Other Sp	3 Removal from S	late	klawn Mem			1, 2009	Rockvil1	e, Maryland		
Balti permit. Departi Import injury	Maple	Funeral Service	MOT	м0130	ا 300	West Mont	tgomery	Avenue, Roc	e/Rockville, kville, Maryl	Land 20850-2805		
Physician /Medical	23a, Part I. Ente failure. List	r the disease, or only one cause								Approximate Interval Between Onset and Death		
kaminer	Immediate Caus or condition res	se (Final disease ulting in death)	a. Narcotic Due to (or as a cons			oxycod	one & :	rentany1)	intoxicat	10m Beatt		
	Sequentially list		b		2							
ted Insit	if any, leading to cause. Enter U (Disease or inju	nderlying Cause	Due to (or as a cons	sequence of): 		- 19					
Exal	events resulting		Due to (or as a cons	sequence of	·):							
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760, Grate be g physici the buri	IF FEMALE:	ent pregnant in th	23c. If yes, outcome	me of pregr			- Fatonia n		23d. Date of deliv	,		
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P.O. es that the igned by be detach	Part II. Other Si	gniricant condit	ions contributing to dea	tn but not re	esurting in the ur	idenying cause	given in Part i			robably 4 V Unknown		
Records, P The law requires 1 freate has been sign 1 gage 2 should be c	-							24a. Was		autopsy findings available to completion of cause of		
Division of Vital Records, tal or attending Physician: The law require its after death. al Director: After this certificate has been siled in by the funeral director, page 2 should bartification: To Be Completed						-			ormed? death	?		
tal Rection: The certificate ector, page		eferred to medica				26.Place		heck only one)				
f Vita Physicia or this ce ral direc	examiner?	2 No			ER/Outpatient		Other ₄ N	Nursing Home 5	Residence 6 Ott	her:		
on of nding I th. :: Afte e funer	27. Manner of D	5 Pend	28a. Date of In (Month, Day)	Year)	28b. Time of In		Yes 2 X N		e now injury occurred			
ivision or Atteno after death Director: I in by the	2 Acciden 3 Suicide		stigation FU 1/20	njury - At ho	Fd 5:00 ome, farm, street	, factory, office I	ouilding, etc.	28f. Location	(Street and Number or	Rural Route Number, City		
Division o spital or Attending hours after death. Ineral Director: After filled in by the fune Certification:	4 Homicio	deter	rmined (Specify)		found i	n house		Dr. Si	lver Spring	illage Gate g, MD		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial—transi Medical Certification: To Be Completed by Physician/Medical E.	29a. Certifier 1 (Check only 1 one) 2	Certifying Pl Medical Exa	nysician: To the best of r miner:On the basis of ex and manner stated	amination a	ge, death occurr nd/or investigation	on, in my opinior	n, death occui	rred at the time, dat	e and place, and due to	the cause(s)		
A 1 2	29b. Signature	and title of certifie	000			29c. Licens O.C.			January 30, 20			
8	30 Name and a	ddress of person	who completed cause of	death (Item	23a)							
OK BKIG		ronica-Pollal	·			111 Penn S	treet, Balti	more, MD 212	01			
State Registra	31. Date filed (A	EB 0 6 2	32. Registr	ar's Signatu	and fact	1						
17271127116		was now " from	/ [45	4 4							

OCME

1 - State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2

Certificate of Death

Rea. No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State Registrar	State of Mar		artment of He			0000	00170
		1. Decedent's Name (First, Middle, Last)		ie Wilkin		Catti	2. Date of Death		3. Time of Death
Physic /Medi		DONNA MARIE		KENS			FEBRUAI	RY 4,2009	9 1:30 A M
Exami	ner	4a. Facility Name (If not institution, give stre LAUREL REGIONAL	,	т.	4b. City, Town, or L			4c. County of Dea	th GEORGES
Funeral	Г	5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day,		thplace (State or Foreign
Director	ļ	218-80-6212 1 M	2 X F	59 Yrs.	monario Dayo	TO CO.	2-14-1	1949 MAI	RYLAND
ryfand how	L	10a. State 10b. County		0c. City, Town or Lo					10d. Inside City Limits
he Ma 28a-f s	Director	MD HOWARD 10e. Street and Number)			OLUMBIA			1 ☐ Yes 2√☐ No
3a or	Dir	9199 WINTERCORN	LANE		10f. Zip Code	045	10	og. Citizen of What Co U . S	,
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. Ther than "natural", or items 23a or 28a-1 show ent, the Medical Ever rivar must be notified at	Funeral	11. Marital Status	Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of His If Yes, specify Cuban	panic Origin? (Sp	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	erican Indian,
)36 rs afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 □Yes 2X No If Yes, Give Year or Dates:	1	1 □Yes 2 XNo	Specify:		Specify: WH	
21215-0036 d within 72 hours aff giene. er than "natural", or	eted	15. Decedent's Educati (Specify only highest grade co	on	16a. Dece	dent's Usual Occupat kind of work done du	ion	ing 1	6b. Kind of Business	
within ene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired) DISAB	-	, ig	DISABI	ED
other	Be Co	17. Father's Name (First, Middle, Last)					e (First, Middle, M		15D
Maryland d 2 should be file th and Mental Hy t7 is marked oth traumatic event	To E	THOMAS NELSO		LKENS		ANNNAM		GOODMAN)	
		19a. Informant's Name/Relationship (Type, VICKI GURSKI/SIS		19b. Mailii 120	ng Address (Street an E. KINGS!	nd Number or Run FON PAR	al Route Number, K LANE		Zip Code)21220 RIVER, MD
altimore, rmit. Pages 1 ar partment of Hee portant: If Item y Injury or othe		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Rem	aval from State	20b. Place of Dispo cemetery, crei	sition (Name of natory or other place)	1	Date 2	0c. Location - City or	Town, State
Itim it. Pag rtment rtant; I		4 Donation 5 Other (Specify)	oval from State	CEDAR H		2-9-	09 E	BALTIMORE	E, MD
Bal permi Depar Impo		21. Signature of Funeral Service Licensee		1 .		ACO AVE		SEDALE FU DALE, MD	JNERAL HOME 21237
		23a. Part 1. Enter the disease, or complicat shock, or heart failure. List only one of	ions that caused the ause on each line.	e death. Do not en				·	Approximate Interval Between
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		CTIVE J	AUNDICE				Onset and Death
Examiner			Due to (or as a c	onsequence of): C MASS					
ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (cras a c						
execut n and al-tran	Examiner	that initiated events resulting in death) Last	MALNUT Due to (or as a c						
68760, ificate be executed g physician and sthe burial-transit	dical	d							
Box 68 leath certific attending p		IF FEMALE:	If yes, outcome of	pregnancy					
e attendin	ician	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tir	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
I Records, P.O. Box E The law requires that the death certif ate has been signed by the attending angle 2 should be detached for use as	Physician/M	9 ☐ Unknown	9 Unknown	-1			00. 01111		
ds, F uires tha signed id be det	þ	Part II. Other significant conditions contrib CEREBRAL PAI		ot resulting in the u	nderlying cause given	in Part I.		acco use contribute to s 2 □ No 3 □ P	robably 4X Unknown
aw requires been seen seen seen seen seen seen se	Completed				,		24a. Was an	24b. Were as	utopsy findings available
al Rec	Com	***					autopsy perform 1 ☐ Yes 2	ed? death?	completion of cause of
Division of Vital Records, I or Attending Physician: The law requires t after death. Director: After this certificate has been signe tin by the funeral director, page 2 should be	Be	25. Was case referred to medical examiner?	oital:	-5	Othor		(Check only one	·	
on of ding Phys	n: To		28a. Date of Injury (Month, Day, Y	2 ER/Outpatier 28b. Time of Injury	K 3 DOA	4 L Nursing no	me 5 Resider 28d. Describe hov	nce 6 Other (Spe w injury occurred	ecify)
SIOP trendir death. tor: Af the fur	catic	1. Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			M 1 □Ye	s 2 No			
DIVISIC al or Attend a after death Director: d in by the f	Certification: To	4 Homicide determined	building, etc. (At home, farm, str Specify) 	eet, factory, office		28f. Location (Str City or Town,	eet and Number or Ri State)	ural Route Number,
Division of Vita To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	Medical C	29a. Certifying Physici (Check only one) Certifying Physici 2 Medical Examiner	an: To the best of r On the basis of exand manner stated	ramination and/or in	n occurred at the time vestigation, in my opin	e, date and place, nion, death occur	and due to the ca red at the time, da	use(s) and manner a te and place, and due	s stated. e to the cause(s)
To th within To th	Me	29b. Signature and title of certifler		0.45	29c. License r			d. Date signed (Mont	
		P Wythe ly		IVID		0064760	F	EBRUARY	4, 2009
5 VY		30. Name and address of person who comp DR. MYTHILY VAN			Print) DEUSEN RO	DAD LA	UREL, M	ID 20707	,
Sta		31. Date filed (Month, Day, Year)	32. Registrar's	Signature			•		
Registr DHMH 17 Rev 1/2		FFR 0 6 2009	General	1. 4	arked				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year ilsor aura 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death If Under 1 Year If Under 24 Hrs. 8. Date of Birth Days Hours Min. (Month, Day, de Itamore oad 6. Sex 7. Age (In yrs. last birthday) Social Security Number Birthplace (State or Foreign Country) Year. 1 □ M 2 🔽 F aryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Brooklandui 11e 1 ☐Yes 2 ☑No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11, Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: Specify: // 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Manutac 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CI 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City r Town, State, Zip Code) 167 8 Brooklandi 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State torest Hill 4 ☐ Donation 5 ☐ Other (Specify) uneral Chape 22. Name and Addr s of Facility 21. Signature of Funeral Service Licenses Funeral Chapel- Honkton 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LARGE CELL LUNG CARCINOMA disease or condition resulting in death) Z MUNTHS Due to (or as a consequence of); Sequentially list conditions, if any, leading to immediate cause Enter Organizing Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 **N**0 2 No 1 ☐Yes 1 🗌 Yes 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner

Physician

/Medical

Examiner

10a State

Funeral

Director

28a-f show

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23a

or items

permit. Pages 1 and 2 should be filed within 72 hours after c. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item any injury or other traumatic event, the temperature.

Director

Funeral

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Completed

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traumatic event, the Medical Examiner must be notified at

and burial-tran physician the burial attending properties for use as 38 been signed by the should be detached certificate has birector, page 2 st After this certific funeral director,

The law requires that the death certificate be executed

Box 68760,

P.0.

Records,

Division of Vital

Hospital or Attending Physician:

Examiner Physician/Medical ð Completed Be Certification: To within 24 hours after death

To the Funeral Director:
completely filled in by the f

Medical

State

Registrar

29a. Certifier

examiner? 1 Yes 2 1√10 27. Manner of Death
1 ₩ Natural 5 Pending

25. Was case referred to medical

2 Accident investigation 6 ☐ Could not be 3 Suicide determined 4 Homicide

(Check only one) 29b. Signature and title of certifier

1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work?

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

00053364

LUTHERVILLE

29c. License number

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

MARYLAND

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

MD

10755 FALLS RD SUITE 300 EBRUARY 5 2009

21093

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM SCOTT QUE ALE

31. Date filed (Month, Day, Year) FER 06 2009 32 Registrar's Signature

			Please '	Type or Pri								.egible.	
		For State Registrar		State of M	laryland		artment d <i>rtificate</i>				_	000	00170
			ne (First, Middle, Las	t)		Cei	lincale	oi Dea	ui	2. Date of De	Reg. No.	2005	3. Time of Death
Physicia			P. WHITE	7						Month JANUAR	Day	Year 2009	
/Medic Examin			If not institution, give	street and number	r)		4b. City, To	wn, or Locati	on of Death	JANUAK		County of De	
			5TH AVENUE	E #101				YATTSV			P	RINCE	GEORGES
Funeral		5. Social Security N	1	9X 7. A □ M 2XCX F	ige (In yrs. la		If Under 1 Y	ear If Un ays Hou	der 24 Hrs. rs Min.	8. Date of Birt (Month, Da	y, Year)		rthplace (State or Foreign Country)
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fter d r Item	Funeral		ried 2 Married	Armed Forces 1 ☐ Yes Y2 If Yes, Give	?	'	f Yes, specify	Cuban, Mex	ican, Puèrto	Rican, etc.)	. '	Black, Wh	
ral", o	l by	3Widowed	4 ☐ Divorced	If Yes, Giver Year or Dates	:		I∐Yes 2√	No Spec	cify:		5	Specify:]	BLACK
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2 sho and I is ma		19a. Informant's N	lame/Relationship (7	ype. Print)		19b. Mailin	g Address (Si	treet and Nu	mber or Run	al Route Numbe	er, City or	Town, State,	Zip Code)
1 and Health em 27 ther to		JONETHA 20a. Method of Dis	AN WATTS /	GRANDSO			55TH AV sition (Name of			HYATTS			
ages nt of h t; if ite		XX Burial 2	☐Cremation 3 ☐	Removal from State	e ce	metery, cren	natory or othe	r place)				•	r Town, State
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Irriportant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		\sim	5 Other (Specify uneral Service Licen:		LINC		EMORIAI . Name and A					ITLANI	
Dep de de de de de de de de de de de de de		* IX	$\mathcal{I} \cap \mathcal{I}$	ONALD R.	GRAY	M	ARSHALI 308 SUI	L'S FU	NERAL ROAD	HOME OF	F MAR LAND	YLAND, MD 20	, INC.)746
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yslcian: The law is certificate has b director, page 2 s	Be	25. Was case reference examiner?	_	Hospital:						(Check only o			GRANDSON'S
ding Phys h. After this funeral di	7: To	1 ☐ Yes 2 ☐ 27. Manner of Deat	th	1 ☐ Inpat	jury 2	R/Outpatien 28b. Time of		Injury at Work?		me 5 ☐ Resid 28d. Describe h			ecify) RESIDENCE
ath. or: Aft	atio	1 Natural 2 Accident	5 ☐ Pending investigation	(Month, D	ay rear)	Injury		work? 1 ☐ Yes 2	No				
l or Attend after death. Director: /	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of ir building, e	njury - At hometc. (Specify)	ne, farm, stre	eet, factory, of	fice		28f. Location (S City or Tow		Number or F	Rural Route Number,
Hospital or Attence thous after death Funeral Director: tely filled in by the		200 Codiffee	VIV Contifuter ===	of sience To the state of	A = f == . 1	de al constitución		h a klas	1				
•To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one)	XX Certifying Phy 2 Medical Exam	iner: On the basis and manners	of examination	nedge, death on and/or inv	occurred at to restigation, in	ne time, date my opinion,	e and place, death occur	and due to the or red at the time,	cause(s) a date and p	and manner a place, and du	as stated. ue to the cause(s)
vithin 24 ho within 24 ho To the Fun completely	Me	29b. Signature art	title of certifier				29c. Li	cense numbe	er		29d. Date	signed (Mor	th, Day, Year)
6		DA	77.W7	-00			HG	0606	5		I	HOLLAKA	3,2009

State Registrar

St. Date filed (Month, Day, Year)

FEB 0 6 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State	State of Marylan		rtment of H <i>tificate of L</i>		Mental Hyg	giene	
			Registrar 1. Decedent's Name (First, Middle, Last)		Cer	uncale of L	Jeam	2. Date of Deat	teg. No. 2	09 03474
	Physici	an						Month	Day	Year 3. Time of Death
may	/Medio		Paul Edward 4a. Facility Name (If not institution, give s	Watson, Sr.		4b. City, Town, or	Location of Dea	<u> Februa</u>	4c. County of	2009 10:55p M
	CXAIIIII	er	21300 New Hampshi	*		Brookev			Montgo	
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year	If Under 24 Hi			Birthplace (State or Foreign
	Director		234-44-0334	^{M 2□ F} 79	Yrs.	Months Days	Hours Mi	Oct. 29	, 1929	Country) WV
	put M		Usual Residence of Decedent 10a. State 10b. County	100 City	, Town or Loc	nation				10d. Inside City Limits
	faryla	5			,					1 ☐ Yes 2√☐ No
	28a-	Director	MD Montgome	ry	DIC	ookeville			0g. Citizen of W	
	3a or	Ö	21300 New Hampshi	ire Avenue			833		US	
	ms 2	Funeral		12. Was Decedent Ever in U.S	S. 13. V	_L Vas Decedent of Hi	spanic Origin?	(Specify Yes or No-	14. Race	- American Indian,
ဖွ	or ite		1 ☐ Never Married 2 🛣 Married	Armed Forces? M☐Yes 2☐No		Yes, specify Cuba ☐Yes 2∭No	n, Mexican, Pue Specify:	erto Hican, etc.)		white, etc. White
003	ural",	d by	3 Widowed 4 Divorced	If Yes, Give 1947–4 Year or Dates:					Specify:	wiire
21215-0036	"natı	Completed	15. Decedent's Educ (Specify only highest grade	ation co <i>mpleted)</i>	(Give I	lent's Usual Occupa kind of work done d OO NOT use retired	uring most of w	orking	16b. Kind of Bus	siness/Industry
7	withir lene. than	dmc	Elementary/Secondary (0-12)	College (1-4or 5+)		Dept. Ma:			Groce	erv
	filed Hygi Sther ent,	BeC	17. Father's Name (First, Middle, Last)		near	Вере. Па.		ame (First, Middle, I		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Eventian roual by neithed at once.	To B	Robert Merle	e Watson			Char	lotte Swe	cker	
ary	shou and N s mai	_	19a. Informant's Name/Relationship (Typ		19b. Mailin	g Address (Street a	and Number or i	Rural Route Number	r, City or Town, S	State, Zip Code)
	and 2 ealth n 27 i		Mrs. Geraldine A. V	Vatson (Wife)	21300	New Ham	pshire .	Avenue Br	ookevill	Le, MD 20833
altimore,	Jes 1 If Iter		20a. Method of Disposition 1 → Burial 2 → Cremation 3 → Re			sition (Name of natory or other place				City or Town, State
Ē	tmen tant:		4 ☐ Donation 5 ☐ Other (Specify)	Mt.	1	el Cemete	the second section is the second section in		Sunshir	ne, MD
Bai	Depar Mpor mpor any in		21. Signature of Funeral Service License	e / L	HA	IGHT FUN	ĔŔĀĽ ^{ility} HOI	ME & CHAP	EL, PA	
			222 Part 1 Enter the disease or compli	actions that sauced the death				ille, MD		Approximate
0.0		8 114	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final		/		y, sucii as carui	ac or respiratory arm	est,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequ	(a NC	٠,٨				LYEAR
	Examiner			Due to (or as a consequ	ici i co i j.					
	D +	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	ience of):					
2	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Examiner	Cause (Disease or injury that initiated events							
38760,	be ex	E E	resulting in death) Last	Due to (or as a consequ	ience of):					
87	physi the b	edical	d							
_	eath certific attending p for use as t	/Me	IF FEMALE:	3c. If yes, outcome of pregnar	ncy				22d Date	of delivery
Box	leath atter	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)			Mon	of delivery hth Day Year
<u>Р</u> О	t the c by the achec	hysi	9 Unknown	9 Unknown		(-,,,,,,,,,,				
	w requires that the d been signed by the should be detached	by P	Part II. Other significant conditions con	tributing to death but not resu	Iting in the un	derlying cause give	n in Part I.	23e. Did tob	pacco use contri	bute to the cause of death?
ğ	equire en siç ould b		KENAL tallure					. 1 ☐ Ye	es 2⊠No :	3 Probably 4 Unknown
ecc	law re as be 2 sho	Completed	Coronary Arte	ry Discace				24a. Was ai	n 24b. W	/ere autopsy findings available
<u> </u>	The law cate has page 2 s	Som						perform	ned? de	eath?
/ita	sician: The certificate I rector, page	Be (25. Was case referred to medical examiner?			1		eath (Check only on		
Division of Vital Records,	Physi this c	2	To les 21410	ospital: 1 Inpatient 2 I	· · · · · · · · · · · · · · · · · · ·		4 🗀 Nursing	Home 5 Reside		· · · · · · · · · · · · · · · · · · ·
- C	ding I	tion	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury Work'	at ? ′es 2 □ No	28d. Describe ha	ow injury occurre	d
S	Atten deatl ctor: y the	ficat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At hor	me, farm, stre		62 5 110	28f Location (St	reet and Numbe	r or Rural Route Number,
<u> </u>	affer affer Dire d in b	Certification:	4 ☐ Homicide determined	building, etc. '(Specify)	-,,		City or Town	n, State)	or Hurai Houte Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certifics completely filled in by the funeral director, p.		29a. Certifier 1 Certifying Phys	ician: To the best of my know	wledge, death	occurred at the tim	e, date and pla	ce, and due to the c	ause(s) and mar	nner as stated.
	he Ho	edical	(Check only 2 ☐ Medical Examin	ner: On the basis of examinat and manner stated.	ion and/or inv	estigation, in my op	oinion, death oo	curred at the time, d	ate and place, a	nd due to the cause(s)
_	To t	Σ	29b. Signature and title of certifier			29c. License	number	2	9d. Date signed	(Month, Day, Year)
	_		1/hms			12/87	46	/	2-64 mg	1,2009
	10		30. Name and address of person who cor	npleted cause of death (Item	23a) (Type, F	Print)	, PI	(0. /	0/ =	(Month, Day, Year) 1, 2009 40 20832
	- 01-	10	31. Date filed (Month, Day, Year)	ASENGOLD, A	ure 4	10101 1	TWLE I h	1/2 20	LNG,	25.800 00
	Sta Begistr		FFR (16 2000	Deal was a fla	Mark	Land .				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Doreen Diana W		er State	te of Maryland				and l	Menta	l Hyg	iene			
21 : :		Registrar 1. Decedent's Name (First, Middle,	act)	Cer	tificate of	Death			12	Reg Date of Death	g. No. 2	00	3-Time of Pearly 7
Physicia Medical Exami		·	Doreen [Month ebruary 4			0710 hrs
6		4a. Facility Name (if not institution, 5506 Eaglebeak Row	give street and number))		Columb	ia				Howard		
Funeral Director		5. Social Security Number 6	. Sex 7. Ag		ast birthday) 85 Yrs.	If Under	Year Days	If Under 2 Hours	Min.		(MM/DD/YYYY)	Foreig	nplace (State or Scotland Intry) -Scotla
		Usual Residence of Decedent								P	Mar 3, 1923		
d now any		10a. State 10b. County	Ontario Ontarion	10c. City,	Town or Location	on		Niag	gra Fa	lls			10d. Inside City Limits 1 Yes 2 No
215-0036 be filed within 72 hours after death with the Maryland nial Hygiene rked other than "natural", or items 23a or 28a-f showent, the Medical Examiner must be notified at once.	Director	10e. Street and Number 3812 St. James Av				10f. Zip Co	ode		1004	10	g. Citizen of Wh		
with the s 23a or e notifie		11. Marital Status	12. Was Decedent	t Ever in U.	S. 13. Was	Decedent	of Hispa		:J2R1	ify Yes or No-	14. Race	- Ameri	Canada can Indian, Black,
P 8 회	Funeral	1 Never Married 2 Married 3 Widowed 4 Divor	1 Yes 2	No		es, specify (,		?uerto Ri	can, etc.)	White	e, etc.	White
2 hours after "natural", Examiner	Š	Widowed 4 Divor 15. Decedent's Education (Specification)	ced or Dates: y only highest grade cor	mpleted)	16a. Decedent	Yes 2	cupation	specify: (Give kir	nd of wor	k done	Specify: 16b. Kind of Bu	siness/li	ndustry
6 172 hou an "nat	leted	Elementary/Secondary (0-12)	College (1-4 or		during mo	st of workir		o NOT us nemal		1)		0	wn Home
5-0036 led within 77 Hygiene. lother than	Comple	17. Father's Name (First, Middle, L	ast)							irst, Middle, N	faiden Surname)		wii nome
AD 21215-0036 2 should be filed within 72 hours after and Mental Hygiene. 27 is marked other than "natural", matic event, the Medical Examiner.	Be		Charles Camp	bell Bo					ì		Mabel Ro		
	To	19a. Informant's Name/Relationshi D. Lois Holden -			1.0					al Route Num I mbia, M [ber, City or Tow D 21045	n, State.	, Zip Code)
re, s l an f Hea If iten		20a. Method of Disposition 1 Burial 2 Cremation	3 Removal from S		Place of Disposi crematory or oth		of ceme	tery,	2-5	Date 99	20c. Location -	•	
C 4 0 = 1		4 Donation 5 Other Spe	cify:			tic Cren			2/17	5 04 200 2009	9-	Gler	Burnie, MD
Baltil permit. Departm Importa		Hormitac	12 Manch	tha	1793	SI 38	ack Fi	uneral d Colu	mbia l	ike Ellico	tt City, MD 2	21043	
Physician /Medical		23a. Part I. Enter the disease, or confailure. List only one cause of	n each line.						diac or r	espiratory arre	est, shock, or hea	art	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Hypertensive A Due to (or as a cons			ovascuia	rDise	ase					
	Ē	Sequentially list conditions, if any, leading to immediate	b	sequence o	f):		_		_				_
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30x 68760 death certificate be attending physical for use as the but	cian/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	I LIVO BII UI		₂ Fe	tal death	3	Ectopic	pregnand	у	23d. Date of Month		Day Year
Box (e death ce the attence ed for use	hysici	1 Yes 2 No 9 V Unkn		at time of de	eath 5 Ot	her (Specif	y)						
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ds, Fequires	ted I									24a. Was	an 24b. \	Were au	topsy findings available
of Vital Records, ng Physician: The law require Niter this certificate has been si meral director, page 2 should b	Completed										rmed?	prior to death?	completion of cause of
of Vital Recting Physician: The After this certificate funeral director, page	O	25. Was case referred to medical				26		f Death (0	Check or				<u></u>
of Viting Physici	To B	examiner? 1 ✓ Yes 2 No		ient 2	ER/Outpatient		^	ther ₄		Home 5	Residence 6 how injury occur		r: Scene
on of anding 1 th. ?: Afte		27. Manner of Death 1 ✓ Natural 5 Pendir	28a. Date of In (Month, Day,	jury ,Year)	28b. Time of I	· ·		s 2 I	- 1	od. Describe	now injury occur	leu	
Division tal or Attendii rs after death. al Director: A	ficat	2 Accident Invest	igation	Injury - At h	ome, farm, stre	et, factory, o	office bui	Iding, etc.	. 2			er or Ru	ral Route Number, City
Division spital or Attend hours after death. neral Director;	Certification:	4 Homicide determ	nined (Specify)						-	or Town, S			
Division of Vital Records, P.O. Box 68760. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b	Medical (29a. Certifier 1 Certifying Phyone) 2 Medical Exam	ysician: To the best of r niner:On the basis of ex	amination a	ige, death occui and/or investiga	red at the ti tion, in my o	me, date pinion, o	and placed	ce, and durred at	ue to the caus the time, date	se(s) and manne and place, and o	r as stat due to th	ed. e cause(s)
To wit	Mec	29b. Signature and title of certifier	and manner stated	1		29c.	License	number			29d. Date sign	ed (Mo	nth, Day, Year)
		my m	, Wir				O.C.M	.E.			February 4	1, 2009	9
0,		30. Name and address of person v Ling Li, MD Assistan	who completed cause of it Medical Examin		_{n 23a)} I Penn Stree	et, Baltim	ore, N	ID 2120	01				
		31. Date filed (Month, Pay, Year) FEB 0 5 2009	32. Registr	rar's Signat	garlo	,					-		
Regis	uer	FED 0 0 2003	Part I	6 6	/								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 18 per fh 888 2-13-09 vt. State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** FEBRUARY 5, 2009 8:55 A M JOHN EDWARD WARD JR. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FOREST HILL HEALTH & REHAB CENTER FOREST HILL HARFORD 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Funeral 1 ☑ M 2 ☐ F Months Days Hours Director Virginia 231-34-5332 May 9, 1932 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits an "natural", or Items 23a or 28a-f show Medical Examiner must be notified at 1 ☐Yes 2 🛣 No Director Maryland Harford Belcamp 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1307 Liriope Ct. Apt. T3 21017 Funeral **USA** 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 5 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Truck Driver Commercial 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental **Fravel** Mary Elizabeth Franci John Edward Ward Sr. Injury or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any injury or other tra once. Elsie M. Ward / Wife 1307 Liriope Ct. Apt. T3, Belcamp, MD 21017 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hilltop Service Corp. 4 □ Donation 5 □ Other (Specify) 2-6-09 Towson, Maryland McComas Funeral Home, P.A. ure∧ofFuneana Seraioe Licensee 1317 Cokesbury Rd., Abingdon, MD 21009 a 1. nie the Approximate Interval Between Onset and Death isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lilure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) asprolion Therion /Medical Due to (or as a consequence of) Examiner CVA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner certificate be executed attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown ate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an certificate has autopsy 2 **N**O 1 | Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of ne Hospital or Attending Pi n 24 hours after death. ne Funeral Director: After ti 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Dave 5 D35522 Fel 5, 200

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VX

Registrar

State

DAVID DUNN

31. Date filed_(Month, Day, Year)

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BEL AIR, MD.

21014

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

615 W. MACPHAIL ROAD

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** rebruary 01, 2004 2009 Georgianna Mae Williams /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Havre De G Under 1 Year | If Under 24 Hrs. onths | Days | Hours | Min. Vursing Home 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months 1 □ M 2 X F 17, Maryland Oct. 214-05-2818 91 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2X No Directo Harford Maryland Havre de Grace 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21078 USA 2103 Williams Drive 2 should be filed within 72 hours after death v s and Mental Hygiene. is marked other than "natural": or items 22 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Specify þ 3 □ Widowed 4 □ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical Elementary/Secondary (0-12) College (1-4or 5+) Public Schools Elementary Educator 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked any Injury or other traumatic eviouse. Hannah Irene Gilbert Theodore Edward Peters 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3196 Gainer Drive, Powder Springs, Georgia 30127 Juanita M. Williams / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □Cremation 3 □Removal from State 2/7/2009 Harford Memorial Gdn. Aberdeen, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Linnsee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final OPD yrs 5 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Undeade or highly that initiated events resulting in death) Last Due to (or as a consequence of): Examiner that the death certificate be executed the burial-trar and Due to (or as a consequence of): Physician/Medical as attending nse 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month Year in the past 12 months? Day 4⊡Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 2 No 3 Probably 4 Nonknown 1 ☐ Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2□ No 1 ☐ Yes 1∐ Yes 2 **X X** 0 Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director Other: 4 Vursing Home 5 | Residence 6 | Other (Specify) 1 Tes 2 No 1 | Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After t Hospital or Attending 24 hours after death. 5 Pending investigation 1 Natural 1 □ Yes 2 □ No 2 Accident Funeral Director: stely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🗁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 24 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Winem 30. Name and address of person who completed cause of death (Item 23a) (Type Print)

Kamman Milhami The Ilee Revelution St 32, Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

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Georg

N. Wiam

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2009 03478 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 11:10 PM 2009 February Carlton E. Whitney 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Rockville
If Under 1 Year | If Under 24 Hrs. Shady Grove Adventist Hospital Montgomery 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Days Months Hours 15 M 2 □ F 85 579-20-6623 January 31, 1924 Washington, D.C. Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 to Yes 2 □ No Rockville Maryland | Montgomery 10g. Citizen of What Country? 10e. Street and Number 20850 21 Pitt Court United States 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Tayyes 2 □ No
If Yes, Give
Year or Dates: WWII 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Financial Officer Government Zı. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carlton E. Whitney Cornelia Peruzzi 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21 Pitt Court, Rockville, Maryland 20850 Doris V. Whitney/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) February 7,2009 Rockville, Maryland Parklawn Memorial Park 22 Name and Address of Facility
Robert A. Pumphrey Funeral Home/Rockville, Inc 300 West Montgomery Avenue, Rockville, Maryland 20850 M01532 23a. Part1. Enter the disease, or complications that caused the death. Shock, or heart failure. List only one cause on each line. Immediate Cause (Final Shock disease or condition resulting in death) Due to (or as a consequence of): Assiration ner monia Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 X No 1 ☐ Yes 2 🕍 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

show

28a-f

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7 Is marked other than "natur traumatic event, the Medical

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death

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

/Medical

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Funeral Director

Completed by

Be ဂ

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours atter death.

Funeral Director: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Physician/Medical Completed by Be

Examiner Certification: To

within 24 hours att

To the Funeral Di

completely filled in

Medical State Registrar

23b. Was decedent pregnant in the past 12 months? 1 ☐Yes 2 ☐No 9 Unknown

1 ☐ Yes 2 🗹 No

5 Pending investigation

27. Manner of Death

1 💢 Natural

2 Accident

(Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier

and manner stated.

28a. Date of Injury (Month, Day, Year)

28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

29c. License number

62167

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28d. Describe how injury occurred

29d. Date signed (Month, Day, Year)

2/2/09

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8600 Old Georgetown Road, Bethesda, Maryland 20814 M.D. Hossein Akhondi,

31. Date filed (Month, Day, Year) FEB 06

29b. Signature and title of certifier

32. Registrar's Signature

1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For	ertificate of Death	Reg. No	0000 00170
	Physicia	an	1. Decedent's Name (First, Middle, Last) CONRAD JOHN ZARZYCKI		Date of Death Month NUARY 3	3. Time of Death 1,2009 9:36 PM
1	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		. County of Death
week!			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	MIDDLE RIVER of If Under 1 Year If Under 24 Hrs. 8, D	Date of Birth	BALTIMORE 9. Birthplace (State or Foreign
	Funeral Director		216 − 34 − 0312 1SEM 2□ F 71 Yrs.	Months Days Hours Min.	Date of Birth Month, Day, Year) -16-193	7 MARYLAND
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	e Mary 3a-fsho	ctor	MD BALTIMORE	MIDDLE RIVER		1 □Yes 2 📉 No
	I within 72 hours after death with the Maryland jiene. r than "natural", or items 23a or 28a-f show the Madical Evenines must be moffled at	Funeral Director	10e. Street and Number 516 GLOUCESTER COURT	10f. Zip Code 21220	10g. Cr	tizen of What Country? U.S.A.
	death	ınera		L. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rical	Yes or No- n, etc.)	14. Race - American Indian, Black, White, etc.
36	rs after	by Fu	1 □ Never Married 2 □ Married 1 ★ □ Yes 2 □ No If Yes, Give 1 Year or Dates: KOREAN	1 ☐ Yes 2 X No Specify:		Specify: WHITE
21215-0036	72 hou 'natura dical E	eted	15. Decedent's Education 16a. Dec	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)	16b. K	kind of Business/Industry
2121	I within jiene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	SALESMAN		DESSERTS
pui	be filed that Hygied of other event, I	Be	17. Father's Name (First, Middle, Last) JOHN ZARZYCKI	18. Mother's Name (Fir. JENNY		n Surname) INKNOWN)
Maryland	12 should th and Mer 7 is marke traumatic	မ	19a, Informant's Name/Relationship (Type, Print) 19b. Mai	ling Address (Street and Number or Rural Ro	oute Number, City	or Town, State, Zip Code) 21220
	s 1 and 2 of Health a item 27 is other trai			GLOUCESTER COURT		C RIVER, MD
Baltimore,	ë = 5		1 Rurial 2 Wiremation 3 Removal from State	position (Name of ematory or other place) CREMATORY 2-2-0		TONSVILLE, MD
altin	permit. Pa Departmen Important: any Injury once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility CVAC	H/ROSED	ALE FUNERAL HOME
	20 E # 9		23a Part 1 Enter the disease or complications that caused the death. Do not e	1211 CHESACO AVE nter the mode of dying, such as cardiac or res	ROSEDA spiratory arrest,	Approximate Interval Between
	Physician		shock, or heart failure. List only one cause on each line.	1 - 2 /	archs	Onset and Death Superior Constant Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of)	mellotas		2000
		ner		MELUNAS		J. Glore
	tificate be executed ig physician and as the burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):			
68760,	te be e ysician ne buria	edical E	d			
x 68	certifica ding ph se as th		IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
Box	death certi e attending id for use a	Physician/IV	23b. Was decedent pregnant 1 Live birth 2 Fetal death 3	B ☐ Ectopic pregnancy □ Other (specify)		Month Day Year
P.0	res that the de signed by the be detached i	Phys	9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
rds,	quires t n signe ald be c	d by	Hypertension		1 □ Yes 2	Probably 4 Unknown
Records,	e law require has been si je 2 should b	Completed by	Certbravazanlar Do	c/don+	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
tal B	ician: The certificate bector, page		25. Was case referred to medical	26. Place of Death (C	1□Yes 2☑N	o 1 Yes 2 No
of Vital	Physicia this cert al direct	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat	ient 3 DOA Other: 4 Nursing Home	5 Residence	6 □Other (Specify)
on c	ding P. h. After t funera	tion:	27. Manual of Death atural 5 Pending 2 Accident Accident Accident 28a. Date of Injury (Month, Day, Year) 28b. Time Injury		. Describe how inju	ury occurred
Division	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit	Certification: To	3 Sulcide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office 28f.	Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
Ω	spital o		29a. Certifier Certifying Physician: To the best of my knowledge, de	eath occurred at the time, date and place, and	I due to the cause	(s) and manner as stated.
	the Horin 24 h	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	rinvestigation, in my opinion, death occurred a		ate signed (Month, Day, Year)
	with cor	2	29b. Signature and title of certifier	4755750		2/2/09
	5 .		30. Name and address of person who completed cause of death (Item 23a) (Typ	1 - 11-11-	n.e. n	1.0 2.1121
	Si	ate	31. Date filed (Month, Day, Year) 32 Registrar's Signature	e jus, salom	WITE IV	10 6,72-1
	Regist		FEB 0 6 2009 De mar 18.	O COLL		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 29. Ruth McNeal Zeller January 2009 5:40 Рм /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carriage Hill Bethesda Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Pennsylvania 8. Date of Birth (Month, Day, Y) Feb. 20, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days 1 □ M 2 □ √F 102 1906 Director 192-36-1700 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Department if Item 27 is marked other than "natural", or Items 23a or 28a-f show amy Injury or other traumatic event, Ite Modical Exponing must be notified at once. 1 X Yes 2 No Director Maryland Montgomery Bethesda 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 20814 9401 Rockville Pike Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊡Yes 2 ሺ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Ś Specify: 3 ₺ Widowed 4 □ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Special Needs Home Dietician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Sherman McNeal Agnes Wize 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9401 Rockville Pike, Bethesda, MD 20814 Linda Zeller-Willard (Daughter) Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2-6-09 Sewickley Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Sewickley, PA 21. Size tuy of Funeral Service Licensee 22. Name and Address of Facility Richard D. Cole Funeral Home and 328 Beaver St., Sewickley, PA 28a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pneumonia /Medical Due to (or as a consequence of): Examiner Urinary Tract Infection Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Failure to Thrive certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Dementia Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month 4 ☐ Pregnant at time of death 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Extreme Age 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performet? Yes 2 No 1 ☐ Yes 2 ☐ No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4^X Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the 29c. License number 29d. Date signed (Month, Day, Year) d title of certifier 29b. Signature D35579 Jan. 30, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 8218 Wisconsin Avenue Suite 305 Susan Miller, MD Bethesda, MD 20814 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 0 6 2009 Registrar

			Please 7	Type or Prin			ndelible Ink partment of H				•		
		1 - For State Registrar		State of Ma	iiyiaiiu		ertificate of		wentai ny	Reg. No		0 031	. Ω
Physic	ian	Decedent's Name (Fill M.T.	rst, Middle, Last	BROOK	-				2. Date of De Month	20,	2009	3. Time of Dea	th M
/Med Exami		4a. Facility Name (If not			5		4b. City, Town, o	r Location of Dea			County of Dea	9:40 P	
Funera Directo		Rockvil 5. Social Security Numb 453-66-2	er 6. Se	TM 2FLE	me (In yrs. las 94	t birthday Yrs.	Rocks // If Under 1 Year Months Days			av. Year)	l Co	OMERY thplace (State or Fo ountry) uisiana	reign
land Dw		Usual Residence of Dec 10a. State 10b	edent c. County		10c. City, 1	Town or I	Location				1	10d. Inside City Li	mits
e Mary la-f sho tified a	Director	MD I	Montgo	mery		Mor	ntgomery	Villag	_{se}			1XX Yes 2[]No
with the	I Dire	10e. Street and Number		n Court			10f. Zip Code	0886		10g. Cit	izen of What Co	•	
DEBILLIMOFE, IMBRYIBING ZIZID-UU30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 X Never Married 3 □ Widowed 4 □		12. Was Decedent E Armed Forces? 1 Yes If Yes, Give Year or Dates:	Ever in U.S.	13	I B. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 1 1 No	lispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or Norto Rican, etc.)	0-	14. Race - Ame Black, Whit Specify:		
72 hou	eted	15. (Specify o	Decedent's Edi	ucation de completed)		16a. Dec <i>(Gi</i> v	edent's Usual Occup re kind of work done DO NOT use retire	eation during most of we	orking		ind of Business	,	
nd ZIZI; e filed within 7 al Hygiene. lother than "r	Completed	Elementary/Secondar	y (0-12)	College (1-4or 5	+)		. DO NOT use retire eacher	d) -		1	sining nool D	rree istrict	
aryiand so should be filed and Mental Hyges marked other umatic event,	To Be C	17. Father's Name (Firs	Brook		,			Ethie	me (First, Middle Simon	Sco	ott		
Mar nd 2 sh lith and 27 is m		19a. Informant's Name/					iling Address <i>(Street</i> 51 Canad						
or other	-	20a. Method of Dispositi	ion	Removal from State	20b. Plac	ce of Disp netery, cr	position (Name of rematory or other pla	ce)	Date	20c. Lo	ocation - City or	Town, State	
altimor mit. Pages partment of portant: If It y Injury or o		4 □ Donation 5 □ 21. Signature of Funera	Other (Specify		Dak	1	emetery 22. Name and Addre		31/09		sining	·	
Departing any Irr		- Colle	NS	Sne	X		246 N. W	L				Home, PA ,MD20850	
Physician /Medical		23a. Part1. Enter the di shock, or heart f Immediate Cause (Fina disease or condition resulting in death)	Ture. List only	one cause on each lir	NARY	ART	TERY DIS		ac or respiratory a	arrest,		Approximate Interval Betwee Onset and Deat	n :h
Examiner per	Examiner	Sequentially list condition any, leading to immediate. Enter Underlyin Cause (Disease or injur	ons, g	b. HYPE	RTEN		1						
BOX 66/6U, eath certificate be executed attending physician and for use as the burial-transit	-	that initiated events ' resulting in death) Last	l	Due to (or as a	a conseque	nce of):							
.C. BOX 6 the death certific y the attending p ched for use as	Physician/Medica	IF FEMALE: 23b. Was decedent pre in the past 12 mor 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	nths?	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal d	eath 3	B⊟Ectopic pregnanc □ Other (specify) _	у			23d. Date of de Month	livery Day Year	r
ecords, P.O. law requires that the datas been signed by the and a should be detached	by	Part II. Other significant Dement		ontributing to death bu	ut not resulti	ng in the	underlying cause giv	ven in Part I.				o the cause of death robably 4 🔀 Unkr	
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VICAL VSICIAN: S certificat director, p	To Be	25. Was case referred texaminer?	7	Hospital: 1 □ Inpatie	nt 2□EF	R/Outnati	ent 3□ DOA Oth	or.	eath <i>Check only</i> Home 5 Res	10	6 □Other (Sec	noife)	
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifici completely filled in by the funeral director.		27. Manner of Death	Pending investigation	28a. Date of Injur (Month, Day	y 2	8b. Time Injury	of 28c. Inju		28d. Describe			еспу)	
LIVIS ital or Atter rs after de ral Directe	Certification:	4 ☐ Homicide	Could not be determined	building, etc	c. (Specify)		street, factory, office		City or To	iwn, State	9)	ural Route Number,	
the Hosp in 24 hou the Fune ipletely file	edical	29a. Certifier 1 (Check only 2 one)	Certifying Phy Medical Exam	ysician: To the best of iner: On the basis of and manner sta	examinatio	edge, de n and/or	ath occurred at the ti investigation, in my	me, date and place opinion, death occ	ce, and due to the curred at the time	e cause(s , date an) and manner a d place, and du	s stated. e to the cause(s)	
	Σ		eep !		MD)		064624		29d. Da	te signed <i>(Mon</i>	th, Day, Year) 21, 2009	9
		30. Name and address Sharma S	of person who d andeep	on MD 109	eath (Item 2 01 C	3a) (Type Onne	ecicut A	ve Kens	sington	, M	D 2089	5	
S Regis	tate trar	31. Date filed (Month, D	23 200		ar's Signatur		whil						
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State of Maryland / Department of Health and Mental Hygien ?

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) January 24, 2009 **Physician** 10:15A_M Charles Alfred Brown /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Charlotte Hall St. Mary's Charlotte Hall Veterans Home b. Date of Birth

9. Birthplace (State or Foreign

Month Pay Year) 4, 1936 Country) If Under 1 Year If Under 24 Hrs. 8, Date of Birth
Months Days Hours Min. Month, Pay. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days 1 XM 2 ☐ F 72 218-30-4858 Maryland Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Charlotte Hall Director St. Mary's Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 20622 USA 29449 Charlotte Hall Rd. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Arged Forces? 1 Pyes 2 No If Yes, Give 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examiner 1 Never Married 2 Married 1 ☐ Yes 2 No White Baltimore, Maryland 21215-0036 Specify: þ 3 ☐ Widowed 4 █ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Delivery Driver Courier 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruby Worley Joseph Brown ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11605 Dumfries Rd., Manassas, VA 20112 19a. Informant's Name/Relationship (Type. Print) **Keith Brown/Son** 20b. Place of Disposition (Name of cemetery, crematory or other place)

Brinsfield-Echols Crem. January 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ACremation 3 ☐ Removal from State 26, 2009 Charlotte Hall, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lis 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., 30195 Three Notch Rd., Charlotte Hall, MD 20622 M00817 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ALZHEIM DISEAS **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 2 🗆 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Winknown DISEASE DISEASE 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1∏ Yes after death.

Director: After this certification in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | □ No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral I completely filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD D67788 .26,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEENA RAO KODAL 31. Date filed (Month, Day, Year) 32 Registrar's Signature State wa & park JAN 28 2009 Registrar

ORIGINAL

Funeral

Director

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 7 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** Metta R. Black January | 20, 2009 2:59 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Heritage Harbour Health and Rehab Anne Arundel Annapolis | Months | Days | Hours | Min. | Nov. 24, 1919 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 🗓 🖁 Minnesota 577-56-8341 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 ☐ No Funeral Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21403 United States P.O. Box 4847 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ∐Yes ⊋∏ No If Yes, Give A Year or Dates: ğ 1 ☐ Yes 2 X No Specify. White Specify: ¥X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be Unknown Unknown 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theodore N. Black / .0226 Falcon Bridge Drive Richmond, Virginia 23238 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1∭Burial 2 ☐ Cremation 3 ☐ Removal from State #illcrest Mem. Gardens 1/24/2009 Annapolis, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Lightsee 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) aldi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 mm ths? 1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 2. No 1 ☐ Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ☑ Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Letitying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title D57028 01-21-09

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 Ridgely Avenue #231 Annapolis MD 21401 Chopra M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 2 2009 DHMH 17 Rev 1/2001 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 330 M BURKE 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday)

10f. Zip Code

1 □Yes 2 No

Computer Programmer

21146

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify

June 05,1921

18. Mother's Name (First, Middle, Maiden Surname)

Mary Kelleher

New Jersey

10g. Citizen of What Country?

Specify:

16b. Kind of Business/Industry

14. Race - American Indian,

Federal Government

White

Black, White, etc.

USA

10d. Inside City Limits

1 ☐ Yes 2 ☑ No

87

12. Was Decedent Ever in U.S.
Armed Forces?
19/Yes 2 D No WWII
19/es, Give Korean
Year or Dates: War

College (1-4or 5+)

War

10c. City, Town or Location

Severna Park

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experiment must be notified at Baltimore, Maryland 21215-0036

Physician /Medical

Examiner

143-14-6220

10e. Street and Number

11. Marital Status

10a. State

MD

Director

Funeral

ģ

Completed

Be

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Usual Residence of Decedent

10b. County

720 Pin Oak Road

1 Never Married 2 Married

3 ₩ Widowed 4 □ Divorced

Elementary/Secondary (0-12)

John Burke

17. Father's Name (First, Middle, Last)

Anne Arundel

15. Decedent's Education (Specify only highest grade completed)

Funeral

Director

Physician /Medical Examiner

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

19a. Informant's Name/Relationship (T		19b. Mailing Address	(Street and Number or Ru	ıral Route Number, Cit	y or Town, State, 2	(ip Code)
Edward M. Burke/ h				Annapolis		
20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 1 4 □ Donation 5 □ Other (Specify,	Hemoval from State	Place of Disposition (Nam cemetery, crematory or oth Veterans Cel	metery 20	009 , Cro	Location - City or ownsville	e, MD
21. Signature of Funery Service Licens	see \	22. Name and Barran 495 Go	Address of Facility CO & Sons, F V. Ritchie H	A. Severna My, Severna	a Park Fu a Park, M	neral Home D 21146
23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the deal					Approximate Interval Between
Immediate Cause (Final diseese or condition resulting in death)	a. Due to (or es a consec	Stay	COPI)	-	Onset and Death
	Due to (or es a consec	quence oi).				
Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a conse.)	wence of):			- 3	
that initiated events resulting in death) Last	C. Due to (or as a consec	quence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	d				23d. Date of deli	iverv
in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of 9 ☐ Unknown				Month	Day Year
Part II. Other significant conditions co	entributing to death but not res	sulting in the underlying ca	use given in Part I.	23e. Did tobacc	/	the cause of death?
				24a. Was an autopsy performed 1 Yes 2	death?	topsy findings available completion of cause of
25. Was case referred to medical examiner?				th (Check only one)		
1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3 DO	Other: 4 I Nursing H	lome 5 Residence	6 ☐ Other (Spec	cify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	3c. Injury at Work? 1 ∐Yes 2 ∐No	28d. Describe how in	ijury occurred	
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, factory, fy)	office	28f. Location (Street City or Town, St	and Number or Ru ate)	ral Route Number,
	ysician: To the best of my kniner: On the basis of examin and manner stated.					
29b. Signature and title of certifier Wellaul	1 24	200.	D W43	8 Ja	Date signed (Montl)	1, Day, Year)
30 Name and address of person who c	ompleted cause of death (Ite	m 23a) (Type, Print)) EFENSE	MGHWA	1 ANNA	POLIS M DLIKE

State Registrar

32 Registrar's Signature

		Pleas	e Type or F								•		•	ble.		
		For State Registrar	State of	Marylan			artmen <i>rtificat</i>				Mental H		ene 20	09	03!	+85
		Decedent's Name (First, Middle,	Last)								2. Date of D				3. Time of	Death
Physici	an	PAUL	ROBERT	BRO	TIT						Month		Day 18 2	Year		
/Medio		4a. Facility Name (If not institution,			AATA		4b City	Town or	Location	of Dooth	JANUA	7.T		2009	9:20	P M
Examin	ıer				ПΛТ					or Death			4c. County			
		FREDERICK A 5. Social Security Number		HOSPI 7. Age (In yrs. i		hdou)	FREI If Under			r 24 Hrs.	8. Date of B	utla	FREI	ERI(- F i
Funeral Director		218-30-7740	1 M 2□ F	7. Age (111 y/3.1		rs.	Months	Days	Hours	Min.	Feb. 2	ay, Y	^(ear) 932	Mar	place <i>(State o</i> intry) y Land	r Foreign
		Usual Residence of Decedent									100. 2	,	1752		, Lana	
land ow		10a. State 10b. County		10c. City	y, Town	or Loc	cation				<u>-</u>				10d. Inside Ci	ty Limits
Many f sh	ō	Maryland Frede	rick	Fre	der	ick									1 ☐ Yes	2 X No
28a-	Director	10e. Street and Number		110	uci		10f, Zip	Codo				100	ı. Citizen of V	/hat Cau		
Aith a or	ā	5821 Etzler Road	a				101, Zip	2170	12			106		5.A.	nuy?	
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s aft	by F	1 ☐ Never Married 2 ☐ Marrie 3 🛣 Widowed 4 ☐ Divorced	If Yes, Give	е		1	☐Yes 2	No No	Specify	<i>'</i> :			Specify	: W	hite	
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, it. Medical Evaniant in the profiled 21 agree.	To Be	Raymond Lee	asij								e Mary			e)		
shot and h s ma		19a. Informant's Name/Relationshi	p (Type. Print)		19b.	Mailin	g Address	(Street &	and Numb	er or Rui	ral Route Num	ber, C	City or Town,	State, Zi	o Code)	
alth a		Edna C. Winfield	d / Siste	r	34	54	Breth	ren	Chur	ch R	load, M	ver	sville	e. M1	21773	3
s 1 a of Hei item othe		20a. Method of Disposition	•	20b. P			sition (Nan				Date	_	c. Location -			
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/Medical Examiner		resulting in death)	Due to (o	r as a consequ	ience o	f):										
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leath certific attending p	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco										23d. Dat	e of deliv	erv	
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vysician: The law requires that the death certificate be its certificate has been signed by the attending physicia director, page 2 should be detached for use as the bur	Be (25. Was case referred to medical examiner?								e of Deat	h (Check only					-
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this c completely filled in by the funeral dire

Baltimore, Maryland 21215-0036

29b. Signature and title of certifie

5 Pending investigation

6 Could not be determined

29c. License number

067657

28c. Injury at Work? 1 □ Yes 2 □ No

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

2009

30. Name didress of person who completed cause of death (Item 23a) (Type, Print)
Anish esai, MD 400 West 7th Street, Fi

28a. Date of Injury (Month, Day, Year)

400 West 7th Street, Frederick, Maryland 21701

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

Medical Certification: To

27. Manner of Death

1 Natural 2 ☐ Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 03486 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day Year January 0623 7,2009 RICHARD TAYLOR BAILEY 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death 4c. County of Death Memorial Hospita Easton albet If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 1**X** M 2□ F Months Days Hours Min 9/9/1927 216-22-0904 81 DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🔀 No KENT MD CHESTERTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5551 QUAKER NECK LANDING RD. 21620 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 □ No IfYes, Give Year or Dates: KOREAN 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify Specify: WHITE 3 Widowed 4 Divorced 16b. Kind of Business/Industry UNITED STATES 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NAVY 12 5+ ENGINEER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HOWARD P. BAILEY OLIVE TAYLOR 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SUSAN M. BAILEY-DURR/DAUGHTER 5730 CROSBY RD. ROCK HALL, MD 21661 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) CHESAPEAKE CREAMTION 1/31/2009 STEVENSVILLES, MD 21. Signature of Funeral Service Licenses HELFENBEIN & NEWNAM FUNERAL HOME 130 SPEER RD. CHESTERTOWN, MD 21620 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final TSOVERON disease or condition resulting in death) Due to (or a a consequence of): nucopantilen Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) to (or as a consequence IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 XYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 □ No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2. No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1X Natural

Physician /Medical Examiner Examine be executed

Physician

Examiner

Funeral

Director

28a-f show

23a or

"natural", or items

Department of Health and Mental Hygiene. mportant: If Item 27 is marked other than any injury or other traumatic event, The Me

Pages '

Baltimore, Maryland 21215-0036

Richard Bailey

Director

Funeral

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Completed

Be

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injury or other traumatic event, the Medical Examinar must be notified at

/Medical

and burial-tran the attending ph the þ signed the bed to detail s certificate has b irector, page 2 sl director,

Box 68760,

After t death.

The law requires that the death certificate P.0. Divísion of Vital Records, Hospital or Attending Physician: To the Hospital or Attendii
within 24 hours after death.
To the Funeral Director: A
completely filled in by the fu

20 State Registrar

Physician/Medical 3 Completed Be ۲ Certification: Medical

2 Accident

3 Suicide

29a, Certifier (Check only one)

4 Homicide

29b. Signature and title of certifier

28a. Date of Injury (Month, Day, Year) 6 Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year.

determined

32. Registrar's Signature

facts (m)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** :20 PM Cora W. Bennett 20 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** TENINBULA MESICAL CENTER 54213BUKG VICOMIC REGIONAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 🖾 F 88 Director 213-12-5912 Feb. 26, 1920 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. Count item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, I'm Medical Examinat must be notified at 11XXYes 2 □ No Director MD Wicomico Mardela Springs 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 105 Church Street 21837 U.S.A. Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 XNo If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No ş Specify. 3 Nidowed 4 Divorced white Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f ment of Health and Mental ant: If item 27 is marked o Emma Bennett Chester A. Wilson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy B. Cooper (Daughter) 36195 Columbia Road Delmar, DE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Important: If it any Injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mardela Memorial Cem 01-24-2009 Mardela Springs, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Short Funeral Home 13 E. Grove Street Home Whout Delmar, DE23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cay e on each line. Immediate Cause (Final Physician disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 9 Unknown 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has certificate 1 □ Yes 2 ☑ No Division of Vital To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tyes 2 [] No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. onel 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

Por

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N 2 1 2000

			1 - State Registrar		-	Cer	tificate of	Death		R	eg. No.	003	03400
, th.	Dhysisi		1. Decedent's Name (First, Middle, Las	t)					2.	Date of Dear	th Day	Year	3. Time of Death
	Physici /Medic		DELLA G. BI	CKLING					E	EBRUA	ARY 1	2009	4:33 p ^M
<i>)</i> -	Examin	er	4a. Facility Name (If not institution, give	· ·			4b. City, Town, o					ty of Death	
			Chester River 5. Social Security Number 6. Se		//n /n n4 /	to destinate a col	Cheste			Date of Birth	Kent		(0).1
	Funeral Director		221-03-3826	M 2 X F 7. Age	97	Yrs.	Months Days	Hours	Min.	(Month, Day July	0 1 9 1	1 1 Ma	ace (State or Foreign try) ryland
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Loc	ation					10	Od. Inside City Limits
	f sho	ō	MD Kent		Ches	ster	Lown						1 ☑ Yes 2 ☐ No
	the 1 28a- notif	Director	10e. Street and Number		0		10f. Zip Code			1	0g. Citizen o	f What Coun	try?
	3a ol		600 Cannon St.	. Apt. 1	16		21620	1			U.S.A	. F	
_	be filed within 72 hours after death with the Maryland tial Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 📉 N			as Decedent of H Yes, specify Cub		in? (Specif , Puerto Ric	y Yes or No- can, etc.)	Bi	ace - America ack, White, e	
Š	urs a al', o Exan	þ	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1	∐Yes 2ÑL No	Specify:			Spec	cify: VVII.	rce
5-0036	72 ho natur dical	Completed	15. Decedent's Edi (Specify only highest grad	ucation de completed)	16	Sa. Deced	ent's Usual Occup ind of work done O NOT use retired	oation during most	of working		16b. Kind of	Business/Ind	ustry
7	within 72 ene. than "na he Medic	ם	Elementary/Secondary (0-12)	College (1-4or 5-							ת הות	. Com	-
7	filed v Hygie other t		12 17. Father's Name (<i>First, Middle, Last</i>)		1	Matr	on of B			irst, Middle, I	Elder		₹
and	d be f ental I ced of	Be C	Harry R. Gary						,	Guire			
<u></u>	shoul nd Me mark mark	۴	19a. Informant's Name/Relationship (7)	ype. Print)	15	9b. Mailing	Address (Street					n, State, Zip	Code)
<u>=</u>	nd 2. alth a: 27 is		James Bickling	g (son)) 9	9108	Medley	Rd.	Minr	neapo]	lis, N	MN. 5	5427
ē,	item		20a. Method of Disposition	14 0	20b. Place ceme	of Dispos	ition (Name of atory or other place	ce)	Date	9	20c. Location	- City or To	wn, State
Ē	Page nent c int: If iny or		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify				lows Ce		ry 2/	/6/09	Smyı	rna,	DE.
Baitimore,	permit. Pages 1 and 2 should be fill Department of Health and Mental H Important: If item 27 is marked oth any injury or other traumatic even once.		21. Signatur Dru eral Servic Licen	11	100510) 22. G	Name and Addre alena F 18 West	ss of Facility	al Ho	ome of	Ster	phen l	L Schaech 21635
			23a. Part1. Enter the disease, or comp	lications that caused	the death. De							PID .	Approximate Interval Between
	Physician	3 4	shock, or hear failure. List only of Immediate Cause, Final disease or condition		rat.	a. 1	men.					- 4	Onset and Death
1	/Medical		resulting in deav.)	a. Due to (as a	consequenc	e of):	Meen	DW.W					
	Examiner		Sequentially list conditions,	b									
	p #	iner	if any, leading to immediate cause. Litter Underlying Cause (Disease or injury	Due to (or as a	consequenc	e of):							
	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a		o of):							
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08/PO	certificate be executed iding physician and ise as the burial-transit	Medical		d									
. Box	death	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	23c. If yes, outcome p 1 ☐ Live birth 4 ☐ Pregnant at	2 ☐ Fetal dea		Ectopic pregnanc Other <i>(specify)</i>	у				Date of delive Month	ry Day Year
л Э	at the I by the	Phys	9 Unknown							00 5:11			
ທົ	requires that the een signed by th nould be detache	þ	Part II. Other significant conditions of	phend but the	por resulting	g in the un	denying cause giv	en in Part I.		1 TY	_		e cause of death? ably 4 ∐Unknown
Hecord	s bee	Completed	O		\cup				1	24a. Was a	n 24b	. Were autop	osy findings available inpletion of cause of
ř	The law cate has b page 2 sl	E								autops perfori 1⊟ Yes	med? 2. No	death?	npietion of cause of 2□ No
VItal	ician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?					26. Place	of Death (C	Check only on			
<u>-</u>	hyslo his ce I dire	To	1 Yes 2 No	Hospital: 1 ☐ Inpatier	nt 2 ER/0			4 Nur	sing Home	5 ☐ Reside	ence 6 □O	ther (Specify)
0	ing P		27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day		o. Time of Injury	28c. Injui Wor			d. Describe ho	ow injury occi	urred	
sion	tendi leath. tor: / the fu	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be					Yes 2 ☐ N					
2	l or At after c Direc	Certification:	4 ☐ Homicide determined	28e. Place of inju building, etc	:. (Specify)	tarm, stre	et, ractory, office		281	City or Town	reet and ivun n, State)	nber or Hurai	Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director,	edical C	(Check only Medical Exam	ysician: To the best of iner: On the basis of	examination	fge, death and/or inv	occurred at the ti estigation, in my	me, date and opinion, deat	d place, and th occurred	d due to the c at the time, c	ause(s) and r late and place	manner as st e, and due to	ated. the cause(s)
	the the the the the the the the the the	Med	29b. Signature and title of certifier	and mapper stat	tea.		29c. Licens	se number		2	9d. Date sigr	ned (Manth I	Dav. Year)
	¥ ¥ ¥ 8		Muli.	191_				060	2.0		2/1	100	
•			30. Name and address of person who d	completed cause of de	ath (Item 22s	a) (Type 5		760	20	,	V (Q	10]	
			Michael E. Pei				peer Rd	. Che	ester	town,	MD.	21620)
	Sta Registi		31. Date filed (Month, Day, Year) FEB 0 6 2	32. Registra	îr's Signature	1. 1	arked						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. Amend Item 26 per phys. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Physician JAN.31, 2009 DORIS WOODS BORNSCHEUER 2:40A /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MORNINGSIDE HOUSE WALDORF CHARLES If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | 8 - 5 - 1922 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign N • Y • **Funeral** 1 □ M 2 🔀 F Months 098-14-8261 Director 86 Usual Residence of Decedent 10a. State 10b. County 28a-f show 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Exerciner must be notified at Director MD. CHARLES WALDORF 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 70 VILLAGE STREET 20602 U.S.A. Funeral items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 0 1 ☐ Yes 2 ☐ No Specify: þ Specify: WHITE 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, Item In once. HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be AGNES NAGELE JOHN P. WOODS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GEORGE BORNSCHEUER-SPOUSE 12104 SILVER MAPLE DR. WALDORF, MD. 20601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🂢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METROPOLITAN CREMATORY 1-31-09 ALEX., VA. 21. Signature of Funeral Service Licensee M00479 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Althemer **Physician** demen disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical the ası IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) the detached 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ Completed 2 No 3 Probably 4 Unknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy certificate 2. No 1 □ Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Yes 2 🕅 No Other: 4 \sum Nursing Home ASSIFU Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this TRESIDENCE 6 1 Other (Specify) funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after deat To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year.

KINS

32. Registrar's Signature

M.D

DHMH 17 Rev 1/2001

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DK

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death **Physician** Day Year Albert Richard 3:50 P.M January 29, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 16513 Sabillasville Rd. Frederick Sabillasville 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ₽ M 2 □ F Months Days Hours 212-24-7192 Director 80 Aug. 11,1928 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show Lry or other traumatic event, It a Medical Evandrat must be required at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Md. Frederick Sabillasville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16513 Sabillasville Rd. 21780 U.S.A 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces?
1 Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates \$ White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Excavator Excavating 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Amanda Pryor ပ John A. Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16513 Sabillasville Rd. Sabillasville,Md.21780 Vada P. Brown (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Pages 1
Department of H
Important: If ite
any injury or oti 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Jan. 31, Smithsburg Crematory 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, Md. 2009 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 12525 Bradbury Ave. J.L. Davis Funeral Home Smithsburg, Md. 21783 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** kung carr 1/20 disease or condition resulting in death) /Medical Due to (or es a consequence of): disease Examiner Coronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical use as the 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery ίοι 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) ed by the detached 9 ☐ Unknown cate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy within 24 hours after death.

To the Funeral Director. After this certificate to completely filled in by the funeral director, pag performe 1 □Yes 2 🗷 No 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2. ☑ No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division 1 Natural 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1-30-09) cause death (Item 23a) (Type 30. Name and address of person who completes Highway 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 5 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3 Time of Death **Physician** Month Patrick Woodrow Buckley /Medical 01 29 2009 1750 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death WMHS-BRADDOCK CAMPUS CUMBERLAND ALLEGANY 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Apr 1, 19 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Days Hours 233-02-5668 50 1958 MD Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits WV Hampshire Springfield Director 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? HC 65 Box 3810 26763 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married 1 □Yes 2 □ No X Specify. ò Specify: 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Service Tech Factory 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marvin Woodrow Buckley Betty April Feller ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HC 65 Box 3810 Springfield WV 19a. Informant's Name/Relationship (Type. Print) Theresa Buckley wife WV 26763 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Ckemation 3 ☐ Removal from State Scarpelli Funeral Home, P.A. 2/2/2009 Cresaptown MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Shaffer Funeral Home 21. Signature o Funeral Service Licensee 230 E. Main Street, Romney, WV 26757 234 Part 1/ Enter the disease shock, or hear railule/ I e, or compleations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Immediate Cause (Final ESOPHAGEAL CARCINOMA disea or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, learning to himmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). Due to (or as a consequence of): Physician/Medical IF FEMALE yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 ☐ Other (specify) Tyes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner

Funeral

Director

28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination must be nealthed.

Baltimore, Maryland 21215-0036

burial-transi and physician s the burial as 1 for use Completed has this certificate Be မ After t Certification

Physician: The law requires that the death certificate be executed

Hospital or Attending

death.

within 24 hours after death To the Funeral Director:

Box 68760.

P.O.

Division of Vital Records,

25. Was case referred to medical

29a. Certifier

Medical

24a Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Mo 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

(Check only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

brato 9 Seton

31. Date filed (Month, Day, Year) 2009

Drive Suite 2040 ymberlan grack.

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State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	erstate of Mi	ai y ia i i	Ce	rtificate of	Dea	ath	Men	ימו רויַ	yglen Reg. N	-) 9	034	192
			1. Decedent's Name	e (First, Middle, La	ist)							ate of D				. Time of De	eath
74	Physicia /Medic		June B.	Caspi							_	nuar				10:12	A^{M}
	Examin	er			ve street and number)			4b. City, Town,		ation of Dea	th		40	Montgo	Death Dmery		
-			Casey Ho 5. Social Security No		Sex 7. Ag	o (In ure k	ast birthday)	Rockvil If Under 1 Year		Inder 24 Hrs	s. 8 r	ate of R	Me	ntgoer	ry	(State or F	Foreign
	Funeral Director		213-30-7		. □	75	Yrs.	Months Days		ours Min	06	Month, E	irth Da <i>y, Year</i> '1933) B Ma	Country)		oreign
	ס		Usual Residence of	Decedent				l .			100	7 - 0 7	1700	, 110			
	arylan show	_	10a. State	10b. County			, Town or Lo	cation								Inside City I 1 X Yes 2	
	8a-f	Directo	MD	Montgom	ery	Beth	esda	101 71 0 1					10.0	*** ****			
	a or 2	Ö	10e. Street and Nun		D 4	2121	•	10f. Zip Code					•	itizen of Wha	Country?		
	leath	Funeral	11. Marital Status	KS HIII	Road, Apt.			20814 Was Decedent of If Yes, specify Cul	Hispan	nic Origin? (Specify	Yes or N	U.S	14. Race - A	American I	ndian,	
5-0036	be filed within 72 hours after death with the Maryland that Hygiene. 3d other than "natural", or items 23a or 28a-f show event, the Modral Examiner I ust be muffled at	by		ed 2 Married	Armed Forces? 1 ☐ Yes 2 ☒↑ If Yes, Give Year or Dates:	No		If Yes, specify Cui 1 □ Yes 2 🖾 No		exican, Puèi ecify:	rto Rica	n, etc.)			Vhite, etc.		
2-0	72 ho natur	Completed	(Spec	15. Decedent's E	ducation ade completed)		(Give	dent's Usual Occu kind of work done	durina	most of wo	orkina		16b. I	Kind of Busine	ess/Indust	ry	
21	ithin ne.	mple	Elementary/Secon	, , , , , , , , , , , , , , , , , , , 	College (1-4or 5	i+)	life.	DO NOT use retir	ed)	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	9		٦,				
2	filed w Hygie other ti	ပိ	17. Father's Name ('First Middle Las			Seno	ol Teach	_	Mother's Na	me (Fir:	st. Middle		ucatio n Surname)	n		
and	d be f ental i	Be c	Jacob Gol		,					irley				n ourname)			
Z.	s 1 and 2 should be filed f Health and Mental Hygi Item 27 is marked other other traumatic event, II	은	19a. Informant's Na		(Type. Print)		19b. Maili	ng Address (Stree						or Town, Sta	te, Zip Co	de)	
Ž	and 2 Health a m 27 is her trai		Ruth Cas	p i- Daugh	ter		5225	Pooks H	i 11	Road,	Ар	t. 3	13N	Bethe	sda.	MD 20	0814
ore,	6 0 L		20a. Method of Disp		7.D	20b. Pl	ace of Dispo	sition (Name of natory or other pla	ace)		Date			ocation - City			
Ĕ	Pages ment of ant: If Its ury or o			5 ☐ Other (Speci	Removal from State	Mt.	Leban	on Cemet	ery	01,	/23/	2009	Ad	lelphi,	MD		
Baltimore, Maryland 2121	permit. Page Department Important: It any Injury o		21. Signature of Fu	neral Service Lice	Dtottlen	neper		2. Name and Addi 10 · 109 Rocl	ess of Ro L Ro kvil	Facility Ed ockvil Lle, M	war le 1 D 20	1 Sa Pike 0852	gel	Funera	l Dii	rectio	n,
			23a. Part 1. Enter the	ne disease, or con	plications that caused one cause on each lir	the death									Ap	proximate erval Betwe	en
1	Physician		Immediate Cause (Final			cular	Accident	t						On	set and Dea	ath
	/Medical Examiner		resulting in death)	•	Due to (or as	a consequ	ence of):										
	LXuiiiiici	<u>.</u>	Sequentially list con	nditions,	b Due to (or as	2 0000000	ence of)-								-		
,	nsit	nin.	Sequentially list conif any, leading to impose. Enter Under Cause (Disease of that initiated events	rlying injury	Due to (or as	a consequ	ence or).										
, †	execting and ial-tra	Examiner	that initiated events resulting in death) L		Due to (or as	a consequ	ence of):										
68760,	ificate be executed physician and is the burial-transit	edical			d												
89		Med	IF FEMALE:						_				- 1		J		
O. Box	The law requires that the death certificate has been signed by the attending age 2 should be detached for use as	Physician/M	23b. Was decedent in the past 12 1 ☐ Yes 2 ☑ 9 ☐ Unknown	months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3	☐ Ectopic pregnar ☐ Other (specify)						23d. Date of Month	delivery Day	/ Yea	ar
J.	w requires that the de been signed by the should be detached		Part II. Other signifi	icant conditions	contributing to death be	ut not resu	Iting in the u	nderlying cause g	iven in F	Part I.		23e. Did	tobacco	use contribut	te to the ca	ause of dea	ith?
rds	quires in sign	d by										1 🗆	Yes 2	2 □ No 3 □] Probably	/ 4 🙀 Unl	known
Vital Records,	e law rec has bee je 2 shou	Completed											s an opsy formed?	24b. Were prior deat	to comple	findings ava	ailable se of
			OF Monages reform	and to modical								Yes	2 X N		Yes 2	No	
	iysician: iis certific director,	o Be	25. Was case referr examiner? 1 ☐ Yes 2 🕱		Hospital:	ant 2□F	-R/Outnatie	nt 3 DOA Ot		Place of De				6 X Other (Connife)	Носъ	ioo
1 O	Attending Physician: In death. ector: After this certific. by the funeral director, p	n: To	27. Manner of Death		28a. Date of Inju (Month, Da	ry	28b. Time o	f 28c. Inji	ury at	LI Nursing				iry occurred	Specity)	Hosp	rce
<u> </u>	endir eath. or: At	atic	2 Accident	investigatio	n	,,,,,,,				2 🗆 No							-
Division of	ial or Att is after de al Direct ed in by t	Certification: To	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined				eet, factory, office			28f. L	ocation City or To	(Street a wn, Stat	<i>nd Number</i> o le)	r Rural Ro	oute Numbe	·r,
	To the Hospital or Attending Phyminin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical	29a. Certifier (Check only one)	1 Certifying P 2 Medical Exa	hyslclan: To the best ominer: On the basis of and manner sta	f examinat	vledge, deat ion and/or ir	h occurred at the vestigation, in my	time, da opinior	ate and place n, death occ	ce, and o	due to th the time	e cause(e, date ar	s) and manne nd place, and	er as state due to the	d. cause(s)	
	withi comp	Me	29b. Signature and	title of certifier	coucitehe	1.6	200	29c. Licer						ate signed (M			
	15		JUCE	yne "	Ducorine	i i		100	63	3748			Janu	ary 21	20	09	
			30. Name and address Jocelyne		completed cause of du, MD 201			Print) ersity P	ark	way]	Balt	imor	e, N	1D 2121	8		
	Sta Registr		31. Date filed (Mont	th, Day, Year) N 2 3 20	33 Registra	ar's Signat	ure Ann	12.0									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2009 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Sara L. Campbell January 2009 5:30 p M /Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 20318 Butterwick Way Montgomery Village Montgomery **Funeral** Social Security Number If Under 1 Year | If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 11/20/1939 9. Birthplace (State or Foreign 1 M 2 K F Director 230-50-5159 69 Virginia Usual Residence of Decedent 10a State 10c. City. Town or Location 28a-f show ral", or items 23a or 28a-f shor Examiner must be notified at 10d. Inside City Limits Director Maruland Montgomeru 1 Tyes 217 No Montgomery Village 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20318 Butterwick Way 20886 permit. Pages 1 and 2 should be filed within 72 hours after death bepartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23 any Injury or other traumatic event, tre Medical Evantinat must any Injury or other traumatic event, tre Medical Evantinat must any Injury or other traumatic event, tre Medical Evantinat must any Injury or other traumatic event, tre Medical Evantinat must appear. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No þ If Yes, Give Year or Dates: Specify 3 X Widowed 4 Divorced White. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Purple Heart Elementary/Secondary (0-12) College (1-4or 5+) Telephone Rep. Donor Service 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Starling Ledford Marjorie Faulkner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth Campbell - Son 20318 Butterwick Way, Montgomery Village, MD 20886 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ី Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Ft. Lincoln Crematory 01/28/2009 Brentwood, MD 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 21. Signature of Funeral Service Licensee Ema 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **5 years** Immediate Cause (Final disease or condition **Physician** Coronary Artery Disease disease or condition resulting in death) years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): nding physician and use as the burial-transit certificate be execut Box 68760,⊗ Due to (or as a consequence of): Physician/Medical use as 1 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant atten 23d. Date of delivery for 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No P.0. 5 Other (specify) Day Year the detached signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, þ Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown page 2 s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate performed Division of Vital 1 ☐Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 K Residence 6 Other (Specify) 1 Yes 2 No ပ this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred Hospital or Attending 1 X Natural 5 Pending nours after death.

neral Director: Af
filled in by the fur investigation 2 Accident 1 □Yes 2 □No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours af

To the Funeral D

completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

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Roji Menon, M.D.,

JAN 23

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

D0057879

10901 Connecticut Ave., Suite 100, Kensington, MD

January 22, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? T = For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 24, Frances Mary Cognazzo January 2009 5:30 p.m^M. 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 47290 Silver Slate Drive St. Mary's Lexington Park If Under 1 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Year) Months Days Hours 1 □ M 2 🗓 F 150-56-5942 50 08/12/1958 New Jersey Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland St. Mary's Lexington Park 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 47290 Silver Slate Drive 20653 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2K Married 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paul Mason Albrecht Alice Hyer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 47290 Silver Slate Drive, Lexington Park, MD 20653 Edward J. Cognazzo/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/30/2009 | Keyport, New Jersey Joseph Cemetery 21. Si matur 31 uneral Servi 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward N. Brinsfield, M00052 22955 Hollywood Road, Leonardtown, MD 20650 Jr. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) JA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

or Items 23a or

'natural'

Department of Health and Mental Hygiv Important: If item 27 Is marked other any injury or other traumatic event, If once.

event, the Medical Examiner must be notified at

Director

Funeral

<u>ک</u>

Completed

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

sician and burial-tran

Examine /sician/Medical

29a, Certifier

29b. Signature and title of certifier

Karen Tucker,

31. Date filed (Month, Day, Year)

JAN 2

attending physician for use as the buria nours after death.

neral Director: After this filled in by the funeral di Cert

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Medical

Hospital or Attending Physiclan: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, 24 hours a within 2 To the

State Registrar

in the past 12 mo 1 Yes 2 144 9 Unknown	onths?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of 9 ☐ Unknown				Month Day Year
Part II. Other significa	ant conditions o	ontributing to death but not res	ulting in the underlying	cause given in Part I.		use contribute to the cause of death?
					24a. Was an autopsy performed? 1 □Yes 2 AN	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred	l to medical		-	26. Place of De	eath (Check only one)	
examiner?		Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 🗆 [OOA Other: 4 Nursing	Home 5 🗓 Residence	6 ☐ Other (Specify)
27. Manner of Death 1 Abatural 2 Accident	5 ☐ Pending investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how inju	iry occurred
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, facto fy)	ry, office	28f. Location (Street a. City or Town, State	nd Number or Rural Route Number, e)

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

40900 Merchants Lane, Leonardtown, MD M.D.

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year Daisy Lee Clark January /Medical 2009 1:00 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death 20 Waibel Wood Lane Port Deposit If Under 1 Year If Under 24
Months Days Hours N Cecil 5. Social Security Number 6. Sex 7 Age (In vrs last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛛 F 91 May 23. Director 184-48-0995 1917 Vi<u>rginia</u> Usual Residence of Decedent 10a. State 10b. County 10c City Town or Location 10d. Inside City Limits 28a-f show ral", or Items 23a or 28a-f sl Examinar must be notified Director 1 ☐Yes 2 No Maryland Cecil Port Deposit the 10e. Street and Number 10g. Citizen of What Country? 20 Waibel Wood Lane 21904 Funeral U.S.A. Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2√□No Specify 2 3 Widowed 4 ☐ Divorced Specify: item 27 is marked other than "natural", other traumatic event, the Modeal Exa Year or Dates: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Eight Years Personal Residence 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ John C. Barnette Minnie Carmack 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health a (Daughter) 20 Waibel Wood Lane, Port Deposit, Maryland Wanda Dixon 21904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
West Nottingham Date 20c. Location - City or Town, State Department of Important: If it any Injury or c 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 01/26/09 Colora, Maryland Cemetery
22. Name and Address of Facility
Lee A. Patterson & Son Funeral Home, P.A.

Maryland 21903-0766 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner (00 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) Box 68760. physician Physician/Medical use as IF FEMALE ves, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Day Vear 5 Other (specify) P.O. ∐Yes 2⊠No certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 3 Probably 4 ☐ Unknown 2 No 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 No 1 □Yes 1 Tyes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) 2/_\M6 Other: 4 Nursing Home Sesidence 6 Other (Specify) 1 ☐ Yes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier **Medical** 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year)

. State

Registrar

30. Name and address of person who completed cause

JAN 23

31. Date filed (Month, Day, Year)

of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Reg. No. 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 13:50 PM 2009 20 1 HOMAS ASHTON CURTIS /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner NICOMICO SAUSSILL Cente REGIONAL MEDICAL TENINSULA 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex Social Security Number **Funeral** Min 1 ■ M 2 □ F Months Days Hours 54 1-4-1955 166-46-0909 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 220 and other traumatic event. 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 Nes 2 No Directo MD SALISBURY WICOMICO 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5691 BAGPIPE COURT 21801 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 KNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SALES REP. PERDUR INC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be MARSORIE SPRATT KICHARD WARD CURTIS ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HOLLY CLUSTIS 5691 BACPIPE COURT SALLSBURY, MD 21/801 (WIFE) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State HEBION CEMETERY 1-26-2009 4 ☐ Donation 5 ☐ Other (Specify) HEBRON IMD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, MESSICKFUNETALHOME PO BOX 61 BLVALVE, MD 21814 Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition resulting in death) **Physician** Intaction Mocardia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Examir Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ Mo Month Dav Year Pregnant at time of death 5 ☐ Other (specify) signed by the a Ö 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 2 No 1 ☐ Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 [] Inpatient this 28a. Date of Injury (Month, Day, Year) funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation death. I Director: And in by the fi 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital of within 24 hours af To the Funeral Discompletely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P.R. 111.C. Hearne no. D

100 E Carroll St. Salisbury MD 21801

32. Registrar's Signature

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

09-00543 Charles Chisley Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Charles Chisley State of Maryland / Department of Health and Mental Hygiene 2009 03497 1- For State Certificate of Death Registrar Reg. No 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Medical Examiner 1018 hrs <u>Charles</u> Chisley January 19, 2009 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Director Country) Washington, Months Davs Hours Min 578-46-6183 1 X M 2 72 March 18, 193 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits District of Columbia Washington 28a-f shov 23a or 28a-f shore. 1 X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 713 Emerson Street, NW 20011 United States with Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. or items must be 14. Race - American Indian, Black, death v If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 X Married Armed Forces? White, etc. Yes 2 X No Widowed Yes, Give Year Yes 2 X No specify: Divorced Black natural q Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Baltimore, MD 21215-0036
permit, Pages I and 2 should be filed within 72 hours
Department of Heafth and Mental Hygiene.
Important: If item 27 is marked other than "natur 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Medical 12 years Warehouse Worker Government 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Leon F. Chisley, Sr. Be Sarah E. Butler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly L. Wall - Daughter 17833 Lochness Circle Olney, MD 20832 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State X Burial 2 crematory or other place) Cremation 3 Removal from State Harmony Memorial Park Jan 26, 2009 Landover, MD Other Specify Signature of Funeral Service 1 c 31 ee 22. Name and Address of Facility Stewart Funeral Home, Inc. Benning Road, NE Washington, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **#**hysician Approximate Interval allure. List only one cause on each line. /Medical Between Onset and a. Lung Cancer complicating Hypertensive Atherosclerotic Cardiovascular Disease Death Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the dea h ertificate be executed Physician/Medical UNPENDED tending physician u e as the burial AMENDED Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death past 12 months? Month Year Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ ₫. Yes 2 No 3 V Probably 4 Completed Records, 24b. Were autopsy findings available 24a. Was an has autopsy prior to completion of cause of performed? death? certificate ✓ Yes 2 No 1 V Yes No To the Hospital or Attending Physician: 25. Was case referred to medical of Vital 26.Place of Death (Check only one) Be examiner? Hospital: 1 V Inpatient Other₄ this ER/Outpatient 3 Nursing Home 5 Residence 6 ို 1 Yes 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 V Natural Division death. Pendina Yes 2 Funeral Director: the 2 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical To the 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 20, 2009 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month State Registrar

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** FATMATA CUMMINGS *Month 53 CM /Medical Januar 2009 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death DOCTORS COMMUNITY HOSPITAL LANHAM PRINCE GEORGE'S 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)FREETOWN 1 □ M 2√□ F Months Days Hours Director 228-53-1875 Yrs. 47 SEPT. 1961 SIERRA LEONE Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, If a Medical Execution roust to rectified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director VA ALEXANDRIA 1 X Yes 2 No ALEXANDRIA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1313 WYTHE STREET Funeral 22314 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 by If Yes. Give 1 ☐ Yes 2 📉 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: BLACK Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th CERTIFIED NURSING ASSIT. PRIVATE 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) S. B. DARAMY ၉ VIOLET ZAC-MACAULAY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SEPTIMUS CUMMINGS/HUSBAND 1313 WYTHE STREET ALEXANDRIA, VIRGINIA 22314 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Pages Department of Important: If it any injury or o once. 20c. Location - City or Town, State 1 IM Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GEORGE WASHINGTON CEME 1/25/2009 ADELPHI, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Onset and Death REAST /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, from the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy signed by the a Month Yes 2X No 5 Other (specify) 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by After this certificate has been si funeral director, page 2 should I 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 2 **Z**No 1 □Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 1 **h**patient 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: A 2 Accident the 1 ☐ Yes 2 No 3 ☐ Suicide 6 Could not be completely filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 18 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State JAN 2 6 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 Year January 21, 6:15 P Dorothy Dolleck 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 □ M 2 T F Months Days Hours July 29, 87 1921 Washington DC 578-18-4518 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location FL Margate 1X Yes 2 No Broward 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 33063 United States 1460 NW 80th Avenue #302 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2 X No Specify: White Specify: 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Molly Mackler Abraham Davidson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ruthie Edelman - Daughter 16008 Wallingford Road Silver Spring MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt Lebanon Cemetery 1/23/2009 Adelphi, MD 22. Name and Address of Facility Edward Sage1. Fund 1091 Rockville 21. Signature of Funeral Service Licensee eral Direction Inc Pike Rockville MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pneumonia Due to (or as a consequence of): Diabetes Mellitus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □Yes 2 No 1 ☐ Yes 2 👿 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 1 Yes 2 No 1 ☑ Inpatient 2 ER/Outpatient 3 DOA $4 \square$ Nursing Home $5 \square$ Residence $6 \square$ Other (Specify) 28d. Describe how injury occurred

Physician /Medical **Examiner**

physician and s the burial-trans

attending pl

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or ite any injury or other traumatic event, the Medical Exercities one.

Saltimore, Maryland 21215-0036

Physician

/Medical

Examiner

Funeral

Director

items 23a or 28a-f show

Director

Funeral

2

Completed

Be

with the Maryland

death v

Examine

Physician/Medical After this certificate has been signed by the funeral director, page 2 should be detached ۾ Completed Be Certification: To

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O.

Box 68760,

	EMALE:
23b.	Was decedent pregnant
	in the past 12 months? 1 ☐ Yes 2 ŽNo
	9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

27. Manner of Death 1 ANatural 2 Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending investigation 6 ☐ Could not be

determined

28a. Date of Injury (Month, Day, Year) 28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

D32332

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Signature and title of certifier

157 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29d. Date signed (Month, Day, Year) January 21, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Sursh K. Gupta MD 9801 Georgia Avenue #220 Silver Spring MD 20902

State Registrar

Medical

31. Date filed (Month, Day, Year)



ours after death.

neral Director: A
filled in by the fu

within 24 hours a

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To the

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2 Date of Death DESJARDINS Pamela Jean 2009 23, 8:10a M. January 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Smithsburg Washington 21855 Jefferson Boulevard If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months 1 □ M 2 🖾 F Pennsylvania 48 Yrs 1960 Dec. 6, 172-54-4612 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Hagerstown Maryland Washington 1 ☑ Yes 2 ☐ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21740 7 East Washington Street Apt 206 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 □ Never Married 2 □ Married white 1 ☐ Yes 2 No Specify: 3 X Widowed 4 □ Divorced Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) beauty shop beautician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Isabell McGowan David Dunkan Coyle, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 918 Clayton Avenue, York, Pennsylvania 17401 Andrew Coyle - son Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Hagerstown Crematory January 27, 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Minnich Funeral Home ure of Funeral Service 415 East Wilson Blvd., Hagerstown, Maryland 21740 20 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Not available Chronic Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Encephalopatny 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No 24a. Was an 1 □Yes 2 ☑ No

Physician /Medical Examiner

executed

law requires that the death certificate be

Box 68760

P.O.

Division of Vital Records.

Physician

/Medical

Examiner

10a. State

Funeral

Director

28a-f show

Director

Funeral

þ

Completed

Be

I and 2 should be filed within 72 hours after death with the Maryla Health and Mental Hygiene. Az 7 is marked other than "natural", or items 23a or 28a-f show the traumatic event, the Medical Exeminational be notified.

permit. Pages 1 and 2: Department of Health a Important: If item 27 is any Injury or other trau

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-transit n signed by the s icate has been significate has been significated by page 2 should b certificate |

Examiner Physician/Medical 3 Completed Be Certification: To After this To the Hospital or Attending PP within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral funeral

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No		26. Place of Death (Check only one)							
		Hospital: 1 ☐ Inpatien	nt 2 ER/Outpatient	3 🗆 [Other			6 Other (Specify)	Sister bon
27. Manner of Deatl 1 ☑ Natural 2 ☐ Accident	5 Pending investigation			М	28c. Injury at Work? 1 □ Yes	2 □No	8d. Describe how inj	ury occurred	
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				2	28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only		nysician: To the best of miner: On the basis of							

one)	
29b. Signature	and title of certifier
	1

29c. License number

D0050882

29d. Date signed (Month, Day, Year) 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Snike 107, Hagerstown Md. 21742 11110 midical cumpus Rd. Neal Patalingings 31. Date filed (Month, Day,

State Registrar

Medical

Year)

32. Registrar's Signature

3H-2